

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>This report is the result of a Recertification Survey at Fircrest Residential Habilitation Center on 10/07/19, 10/08/19, 10/09/19, 10/10/19, and 10/11/19. Eight Sample Clients were chosen from a census of 108 Clients and two Expanded Sample Clients were added during the survey. The facility was found to have deficient practices and the Condition of Participation for Active Treatment was determined to be out compliance.</p> <p>This survey was conducted by: Arika Brasier Linda Davis Gerald Heilinger Patrice Perry Justin Smith Olivia St. Claire</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504</p> <p>Telephone: (360) 725-2484</p>			W 000			This document was prepared by Residential Care Services for the Locator website.
W 104	<p>GOVERNING BODY CFR(s): 483.410(a)(1)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by:</p>			W 104			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE			(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	<p>Continued From page 1</p> <p>Based on observation, record review, and interview, the facility's Governing Body failed to:</p> <p>1. Provide oversight of the kitchen to ensure Clients at the Activity Building received the correct meal for lunch on 10/09/19. This failure resulted in all Clients receiving ground meat, instead of meatballs.</p> <p>Findings included ...</p> <p>Observation at the Activity Building on 10/09/19 at 11:36 AM showed staff served Client #1 ground meat for lunch.</p> <p>Observation of the menu board at the Activity Building on 10/09/19 at 11:45 AM showed meatballs were on the lunch menu for that day.</p> <p>During an interview on 10/09/19 at 11:55 AM, Staff S, Adult Training Specialist 2, stated that the kitchen delivered ground meat for lunch, not meatballs.</p> <p>During an interview on 10/10/19 at 1:13 PM, Staff Q, Food Service Manager, stated that the Activity Building should have had meatballs for lunch on 10/09/19, not ground meat.</p> <p>2. Provide oversight to ensure the Qualified Intellectual Disability Professional (QIDP) implemented one of eight Sample Clients' (Client #1) Individual Habilitation Plan (IHP) within the facility's policy time line. Client #1's IHP, dated 09/12/19, was not finalized or filed in her record. This failure resulted in Client #1 not having a current IHP available to staff.</p>	W 104		This document was prepared by Residential Care Services for the Locator website.	

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W 104	<p>Continued From page 2</p> <p>Findings included ...</p> <p>Review of Client #1's file showed an IHP Revision, dated 09/12/19 that identified Client #1 had an IHP meeting on 09/12/19, because she had a significant change in condition. The 09/12/19 IHP was not in the Client's file on 10/07/19, 25 days after the IHP meeting.</p> <p>Record review of Developmental Disabilities Administration (DDA) policy 103.1 titled, "Individual Habilitation Plans," dated 07/01/19, showed the Habilitation Plan Administrator (HPA- also known as a QIDP) must finalize and file the IHP within two weeks of the IHP meeting.</p> <p>During an interview on 10/07/19 at 12:50 PM, Staff F, Program Area Team (PAT) Director, stated that staff did not finalize or file the IHP within 2 weeks of the IHP meeting.</p> <p>3. Provide oversight of their policy to address end-of-life decisions for one of eight Sample Clients' (Client #1) significant change in her physical condition. This failure resulted in Client #1's plan of care not being updated, the Client/guardian were not educated on the Client's right to receive palliative care/hospice care, and the facility did not fully acknowledge her end-of-life decisions.</p> <p>Findings included ...</p>			W 104			This document was prepared by Residential Care Services for the Locator website.

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W 104	<p>Continued From page 3</p> <p>Review of Client #1's file showed a Physician Order for Life Sustaining Treatment (POLST), dated 08/18/19. (A POLST indicates what life sustaining treatment a person wants in the event of a medical emergency and indicates what types, if any, of heroic measures they want to save their lives.)</p> <p>Record review of DDA policy 17.01 titled, "SUPPORTING END-OF-LIFE DECISIONS IN RESIDENTIAL HABILITATION CENTERS," dated 06/15/18, showed the facility must discuss and document end-of-life choices (including palliative care/hospice care) with the Client and their legal representative. The policy showed that the facility must document the discussion in the Client record. The policy also showed that the QIDP or Registered Nurse (RN) must update the IHP or the plan of care with the end-of-life decisions discussed in the meeting.</p> <p>Review of Client #1's file showed a Medical Provider Progress Note, dated [REDACTED]/19. Client #1 returned to the facility on [REDACTED]/19 from a hospitalization where she was treated for the worsening of her [REDACTED]. A QIDP Review, dated 10/10/19, showed a note on 08/22/19 that stated, "HPA [Habilitation Plan Administrator] contacted guardian to confirm the family wants to keep the POLST-DNR [Do Not Resuscitate] order that was drafted while client was in the hospital. The guardians wish to keep the POLST-DNR in place." There was no documentation regarding a discussion of</p>	W 104		This document was prepared by Residential Care Services for the Locator website.	

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W 104	<p>Continued From page 4</p> <p>palliative/hospice services, an IHP revision, or nursing care plan in relation to the heart failure. See W260 and W333 for additional details.</p> <p>During an interview on 10/10/19 at 8:10 AM, Staff P, QIDP, stated that staff did not complete an IHP revision that incorporated the information from the POLST. Staff P stated that the nursing department was responsible for the update to the Client's plan.</p> <p>When asked if Client #1 had a care plan related to her POLST during an interview on 10/10/19 at 10:05 AM, Staff O, RN, stated that they had a meeting and Client #1 was the only one in the Intermediate Care Facility with a POLST.</p> <p>4.To ensure they had a process for all staff to follow that identified how the facility would manage their Client record system, including, but not limited to: what to file in the Client record, how the maintenance of the record occurred, and who would maintain it. Some assessments were located in a physical file and some were on the facility online SharePoint. This failure resulted in one of eight Sample Clients (Client #1) having an incomplete record.</p> <p>Findings included ...</p> <p>Record review of Client #1's Comprehensive Functional Assessment on 10/07/19 showed:</p> <p>An Annual Healthcare Assessment (AHA), dated 08/24/18</p> <p>A Direct Care Independent Living Skills</p>			W 104			This document was prepared by Residential Care Services for the Locator website.

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W 104	<p>Continued From page 5</p> <p>Assessment, dated 03/14/19</p> <p>A Money Management Assessment dated 04/03/19</p> <p>Record review on 10/07/19 of Client #1's IHP Revision, dated 09/12/19, showed the facility held Client #1's IHP meeting on 09/12/19. The September 2019 IHP was not in the Client's record.</p> <p>During an interview on 10/07/19 at 12:50 PM, Staff F, PAT Director, stated that Client #1 had a significant change in condition and staff completed assessments for a new IHP. Staff F stated that the updated assessments and the IHP were not in the Client's record. The state surveyor requested a copy of facility policies related to Client assessment and IHP.</p> <p>Record review of DDA policy 103.1 titled, "Individual Habilitation Plans," dated 07/01/19, showed no instructions for filing the assessments used to develop a Client's IHP.</p> <p>During an interview on 10/07/19 at 1:21 PM, Staff F stated that the facility did not have a policy showing who filed assessments, how long after completion the assessments would be filed, or how the facility would maintain Client records. Staff F stated that Client #1's assessments and IHP were located on the facility shared data online, unavailable to Direct Care Staff, Clients, and guardians.</p> <p>Record review of documents provided by the facility at 1:29 PM on 10/07/19 showed: An updated AHA dated 08/26/19 was not in Client #1's physical record.</p>	W 104		This document was prepared by Residential Care Services for the Locator website.	

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W 104	<p>Continued From page 6</p> <p>A Direct Care Independent Living Skills Assessment, undated, IHP dated 09/12/19, was not in Client #1's physical record.</p> <p>A Money Management Assessment dated 09/05/19 was not in Client #1's physical record.</p> <p>During an interview on 10/07/19 at 1:29 PM, Staff G, DDA 1, stated that staff obtained the Client's assessments and IHP from the facility online SharePoint.</p> <p>5.Ensure staff entered all Client assessments into their physical record after completion of the assessments. This failure resulted in staff, Clients, and guardians not having current information available in the Client's record.</p> <p>Findings included ...</p> <p>Record review of Client #1's record showed a Medical Provider Progress Note, dated 08/26/19, that indicated the physical exam for Client #1's AHA was on 08/26/19. The 2019 AHA was not in the Client's record.</p> <p>During an interview on 10/07/19 at 1:21 PM, Staff F, PAT Director, when asked for the facility policy for filing documents in Client records, stated that they did not have a specific policy that directed staff to file documents in Client records.</p> <p>6.Develop a process to ensure staff obtained routine Client weights, or weights as ordered by a Physician. There was no process to ensure weights were obtained under consistent conditions, such as but not limited to, what time of day to obtain the weight, what clothing the</p>	W 104			This document was prepared by Residential Care Services for the Locator website.

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W 104	<p>Continued From page 7</p> <p>Client should wear, how to resolve a difference in weight, how to analyze and report weight changes, or what action to take if staff did not obtain a weight. This failure prevented the facility from identifying changes in Client's weights, prevented staff from implementing interventions related to weight changes, and identifying if an appropriate plan was in place for Clients requiring weight monitoring.</p> <p>Findings included ...</p> <p>Review of Client #1's file showed a diagnosis of [REDACTED]. Client #1 required an Intravenous diuretic (medication to reduce the amount of fluid in the body that is delivered directly into a vein) while at the hospital to get rid of fluid from her lungs. (Fluid retention is a common symptom of heart failure and monitoring a person's weight is a simple way to identify early fluid retention.)</p> <p>Record review of Client #1's Medication Administration Record (MAR) for October 2019 showed staff would weigh her once a week on Friday mornings. There was no weight documented for October 4, 2019. Staff did not write the last weekly weight on the October MAR as a reference to enable the Licensed Nurse to determine if the weight was stable. There were no instructions for staff to follow if there was a weight gain or weight loss. There were no instructions for staff to follow to ensure consistent conditions while weighing Clients.</p> <p>During an interview on 10/10/19 at 10:05 AM, Staff O, RN, stated that the facility did not have a</p>	W 104		This document was prepared by Residential Care Services for the Locator website.	

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W 104	Continued From page 8	W 104		This document was prepared by Residential Care Services for the Locator website.	
W 110	process to follow to ensure consistent conditions while weighing Clients. CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that includes a separate record for each client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop a written process to manage Client records for one of eight Sample Clients (Client #1), which included, but not limited to: what documents would be filed in a Client record, how the Client record would be kept current, and who would keep the record current. Some Client assessments and other documents were located on the facility Share Point online, not in the physical record. This failure resulted in Client information being located in various places, potentially causing delay in treatment, and decisions based on partial information that would affect Client health, safety, and training. Findings included ... Record review of Client #1's physical record on 10/07/19 showed: an Annual Healthcare Assessment (AHA), dated 08/24/18. There was no AHA for 2019. a Direct Care Independent Living Skills Assessment, dated 03/14/19 a Money Management Assessment dated 04/03/19	W 110			

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W 110	<p>Continued From page 9</p> <p>On 10/07/19 at 1:26 PM, Staff G, Developmental Disabilities Administrator 1, provided the following documents from the facility online system after a state surveyor requested current assessments.</p> <p>An AHA dated 08/26/19</p> <p>A Direct Care Independent Living Skills Assessment, undated, with an Individual Habilitation Plan date of 09/12/19</p> <p>A Money Management Assessment dated 09/05/19</p> <p>During an interview on 10/07/19 at 1:21 PM, Staff F, Program Area Team Director, stated that the facility did not have a policy that identified what a Client record was (physical file versus electronic file or a hybrid version with some documents being stored physically and some electronically). Staff F also stated that there were no instructions for staff to file completed Client assessments once they were completed. Staff F stated that the facility kept the completed assessments on a shared data site at the facility and portions of the Interdisciplinary Team, such as Direct Care Staff, Clients, and their guardians could not access the shared data site.</p>			W 110			This document was prepared by Residential Care Services for the Locator website.
W 111	<p>CLIENT RECORDS</p> <p>CFR(s): 483.410(c)(1)</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the</p>			W 111			

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W 111	<p>Continued From page 10</p> <p>facility failed to ensure one of eight Sample Clients (Client #1) had a complete record that reflected her current medical condition and her functional abilities. Her Annual Healthcare Assessment (AHA) was not in her record 42 days after completion of the assessment. Additional assessments and a new Individual Habilitation Plan (IHP) were completed and the documents were stored on the facility online SharePoint, not in the physical record. This failure prevented staff from having current information available and prevented the Client/guardian access to the information.</p> <p>Findings included ...</p> <p>Record review of Client #1's Comprehensive Functional Assessment on 10/07/19 showed:</p> <p>An Annual Healthcare Assessment, dated 08/24/18</p> <p>A Direct Care Independent Living Skills Assessment, dated 03/14/19</p> <p>A Money Management Assessment dated 04/03/19</p> <p>Record review on 10/07/19 of Client #1's Individual Habilitation Plan (IHP) Revision, dated 09/12/19, showed the facility held Client #1's IHP meeting on 09/12/19. The September 2019 IHP was not in the Client's record.</p> <p>During an interview on 10/07/19 at 12:50 PM, Staff F, Program Area Team Director, stated that the facility did not have a policy that provided a time line for staff to place completed assessments in the Client record.</p>	W 111		This document was prepared by Residential Care Services for the Locator website.	
W 124	PROTECTION OF CLIENTS RIGHTS	W 124			

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W 124	<p>Continued From page 11 CFR(s): 483.420(a)(2)</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to discuss and document the risk and benefit of medical treatment for one of eight Sample Clients (Client #1). The facility did not provide the Client and her guardian with information to make an informed decision regarding the risk and benefit of various treatment options. This resulted in the facility making treatment decisions rather than ensuring the Client and her guardian had detailed information and alternative choices to determine if the risk of falling and being significantly injured was greater than the potential of having a stroke, or if other medications/treatments were a better alternative.</p> <p>Findings included ...</p> <p>Record review of Client #1's file showed:</p> <p>The facility doctor prescribed a blood thinning medication to decrease her risk of developing a blood clot or having a stroke because Client #1 had an irregular heartbeat. The type of medication prescribed to Client #1 does not have a treatment to reverse the thinning of the blood.</p>			W 124			This document was prepared by Residential Care Services for the Locator website.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 124	<p>Continued From page 12</p> <p>The Client was at increased risk of significant bleeding while taking the medication to prevent a blood clot.</p> <p>The facility determined her current risk of having a stroke within the next year was 6%.</p> <p>Client #1 fell 6 times in the last year, she went to the hospital with a bleeding head wound which was a result of a fall, and while at the hospital they diagnosed her with [REDACTED], demonstrating that Client #1 was at high risk for another fall resulting in significant injury.</p> <p>Review of Client #1's file showed no documentation of a discussion between the facility and the Clients guardian regarding the risk of taking a prescription blood thinner when Client #1 had a recent fall with a significant bleeding head injury that resulted in an Emergency Room visit, and a documented history of falls. An Individual Habilitation Plan Revision, dated 07/25/19, identified, "[Client #1's first name] has experienced a number of falls over the last calendar year and it is evident that her mobility is beginning to decline."</p> <p>During an interview on 10/10/19 at 10:05 AM, Staff O, Registered Nurse, when asked if Client #1's guardian had been informed of the risks, stated that the Client's team had discussed the risk of continuing the medication versus discontinuing it. Staff O was unable to provide documentation of the discussion concerning the risk of continuing the medication versus the risk of discontinuing the medication.</p>	W 124			This document was prepared by Residential Care Services for the Locator website.
W 125	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)</p>	W 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 125	<p>Continued From page 13</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to protect one of eight Sample Clients' (Client #5) rights. The facility made Client #5 use adaptive equipment while eating despite the facility Human Rights Committee's (HRC) disagreement with the rationale for use, and lack of approval for the equipment. This failure resulted in Clients being vulnerable to the facility doing what the facility wanted rather than ensuring the protection of Clients, making the HRC irrelevant, when the intention of the HRC was to protect Client rights.</p> <p>Findings included ...</p> <p>Observation on 10/09/19 at 5:05 PM at 318 House showed Client #5 used an inner-lipped plate and a small fork while eating dinner.</p> <p>Review of Client #5's file showed a Fircrest RHC (Residential Habilitation Center) Informed Consent, which listed the use of small utensils and an inner-lipped plate during meals. It showed HRC did not agree with the rationale for the restriction and did not approve its use.</p> <p>During an interview on 10/10/19 at 9:10 AM, Staff C, Qualified Intellectual Disability Professional, stated that the HRC had not approved the restriction and use of adaptive dining equipment</p>			W 125			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 125 W 157	<p>Continued From page 14 for Client #5.</p> <p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete corrective action to address an identified deficiency from an investigation for one Expanded Sample Client (Client #10). Staff placed Client #10 in an emergency hold without authorization from a Qualified Intellectual Disability Professional (QIDP), as facility policy instructed. The facility's investigation failed to identify the need for staff training for emergency restraint procedures. Client #10's rights were violated, and without training all staff on emergency restraint procedures, all Clients were vulnerable to being restrained without proper authorization.</p> <p>Findings included ...</p> <p>Record review of a facility 5-Day Investigation, with no Incident Report number, showed staff placed Client #10 in a seated restraint on 09/05/19 after he repeatedly tried to enter another Client's room. Client #10 did not have a seated physical restraint as an approved intervention in his Positive Behavior Support Plan (PBSP). Therefore the restraint would have been categorized an emergency restraint, requiring the authorization from a QIDP.</p> <p>During an interview on 10/10/19 at 1:05 PM, Staff</p>	W 125 W 157			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
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W 157	<p>Continued From page 15</p> <p>G, Developmental Disabilities Administrator (DDA) 1, when asked if there was a written policy or procedure regarding emergency restraints, could not provide the Surveyor with one.</p> <p>During an interview on 10/07/19 at 1:21 PM, Staff F, Program Area Team (PAT) Director, stated that the facility used DDA policies at the facility.</p> <p>Record review of DDA policy, "Restraints 5.11," dated 01/03/12, showed that for emergency procedures the QIDP or medical professional must authorize the least restrictive response. It showed the QIDP must document the authorized procedure used, the justification for its use, and the length of time implemented.</p> <p>Record review of the facility's Plan of Correction (PoC) for the 5-Day Investigation showed they would retrain staff on the Client's PBSP. It did not show any retraining of emergency restraint procedures.</p> <p>During an interview on 10/10/19 at 1:05 PM Staff G, DDA 1, stated that if a Client was placed in an emergency restraint then a QIDP should be called as part of the process. She stated that she was unsure why a QIDP was not involved in this case. She stated that staff working with the Client might not consider restraining him as an emergency restraint.</p> <p>During an interview on 10/10/19 at 1:11 PM, Staff F, PAT Director, stated that if staff did not follow the emergency restraint procedure and the PoC did not address it, then it was not a sufficient PoC.</p>	W 157		This document was prepared by Residential Care Services for the Locator website.	
W 159	QIDP	W 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 159	<p>Continued From page 16 CFR(s): 483.430(a)</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure their Qualified Intellectual Disability Professional (QIDP) oversaw every part of three of eight Sample Clients' (Clients #1, #2, and #5) active treatment training plans. The QIDP did not update Client #1's bathing program to reflect her current training. The QIDP did not ensure: Client #2's teaching plans provided clear instructions for staff to implement; his active treatment schedule did not reflect his most current Individual Habilitation Plan (IHP); Direct Care Staff (DCS) did not implement teaching plans as written, did not record data as required for analysis; and the Client's programs were not updated when objectives were achieved. The QIDP did not change Client #2's programs when refusals occurred or when no progression occurred over several months of teaching the same objective. The QIDP did not train Client #5's DCS when a program's time was changed from AM to PM, his teaching plans had conflicting prompts for DCS, DCS did not provide data to analyze programs, his training instructions were not changed when his work schedule changed, and his rights were restricted without the authorization from the Human Rights Committee (HRC). The lack of oversight by the QIDPs perpetuated the dysfunction within the facility's Active Treatment loop.</p> <p>Findings included ...</p>	W 159		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 159	<p>Continued From page 17</p> <p>Client #1</p> <p>Record review of Client #1's QIDP Review, dated 09/30/19, showed Client #1's Interdisciplinary Team (IDT) met in July 2019 and agreed to progress her to the next step of her training plan for bathing, washing her legs (step 3 of the training).</p> <p>Record review of Client #1's August and September 2019 training plan showed the objective for Step 2 of the program, not Step 3 as indicated by the 09/30/19 QIDP Review and IDT agreement to update her plan.</p> <p>During an interview on 10/10/19 at 8:10 AM, Staff P, QIDP, stated that staff were implementing step 3 of the training. Staff P stated that the plan was not updated.</p> <p>Client #2</p> <p>The QIDP failed to update Client #2's Active Treatment Schedule to reflect his current IHP. See W250 for details.</p> <p>The QIDP failed to provide oversight to ensure correct implementation of training programs (using a boot scraper and to communicate a choice) for Client #2. Staff did not provide the verbal cues or follow the instructions as written in the training programs. See W251 for details.</p>			W 159			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
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W 159	<p>Continued From page 18</p> <p>The QIDP failed to ensure staff collected data as directed on six of ten formal training programs (handwashing, bathroom privacy, meal cleaning, money denomination, room cleaning and communicate a choice) for Client #2. These were skill acquisition programs with no data collected over different days and shifts. See W252 for details.</p> <p>The QIDP failed to ensure Client #2's training program for Handwashing was reviewed for new training opportunities when the collected data showed Client #2 learned the skill. See W255 for details.</p> <p>The QIDP failed to ensure changes were made to Client #2's training programs (money denomination, tying shoes, and room cleaning) when the QIDP Review showed no progress had occurred since February of 2019 on these programs. See W257 for details.</p> <p>Client #5</p> <p>Staff training and monitoring of programs</p> <p>Observation on 10/09/19 at 318 House at 7:15 PM showed the DCS working with Client #5 asked another DCS about when to implement his lunch training program. They both stated that they were confused because it used to be implemented in the PM but now the program had PM crossed out and AM written in.</p>			W 159			This document was prepared by Residential Care Services for the Locator website.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	<p>Continued From page 19</p> <p>Record review of Client #5's Lunch training program (packing his lunch to take to work), dated October 2019, showed the time to implement the program was originally typed PM and then was crossed out and AM had been hand written in.</p> <p>During an interview on 10/09/19 at 7:20 PM, Staff A, Attendant Counselor Manager, stated that staff should implement Client #5's lunch program in the AM. When asked how staff are trained when changes occur to a training program she stated that staff are in-serviced regarding the changes by the QIDP and then sign off that they have received the training. When asked for documentation of the in-service sheet for the change to Client #5's lunch training program, Staff A could not provide any.</p> <p>The QIDP failed to ensure that staff did not implement adaptive dining equipment restrictions for Client #5 after the HRC denied the restriction. This resulted in Client #5's rights being restricted without due process, See W125 for details.</p> <p>The QIDP failed to provide clear instructions within a teaching plan (learning to rinse his hair) when it gave conflicting prompts for staff to use related to the training objective for Client #5. See W234 for details.</p> <p>The QIDP failed to ensure data was documented when required (cutting food, money denomination, sweeping, self-calming, and</p>			W 159			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	Continued From page 20 problem-solving) which resulted in a lack of data to accurately analyze Client #5's progress in each of these skills. See W252 for details.	W 159		This document was prepared by Residential Care Services for the Locator website.	
W 195	<p>The QIDP failed to monitor teaching plans (copying trip slips and packing a lunch for work) and make modifications when Client #5's work scheduled changed. This resulted in staff not implementing Client #5's teaching plans. See W255 for details.</p> <p>ACTIVE TREATMENT SERVICES CFR(s): 483.440</p> <p>The facility must ensure that specific active treatment services requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure they had a system to provide four of eight Sample Clients (Clients #1, #4, #6, and #7) with active treatment. Client #1 did not have training throughout the day. Client #4 refused most training activities and there was no plan to address this which resulted in a lack of training throughout his day. Client #6 was in constant motion throughout most of the day and there was no plan to address this which resulted in a lack of training throughout her day. Client #7 often refused to do things when staff approached him and there was no plan to address this which resulted in a lack of training throughout his day. Lack of a system to provide aggressive active treatment services to Clients prevented them from learning the skills they needed to increase their independence and</p>	W 195			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 195	Continued From page 21 move out of the facility.	W 195		This document was prepared by Residential Care Services for the Locator website.	
W 196	Findings included ... Observation, record review and interview showed Clients #1, #4, #6, and #7 did not have aggressive training programs to teach them skills they needed to increase their independence. See W196 for details. ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide aggressive active treatment for four of eight Sample Clients (Clients #1, #4, #6, and #7). Client #1 had a lack of training programs that would occupy most of her day. She spent long periods of the day sitting around, without training. Client #4 and #6 experienced numerous missed opportunities for training. There was no assessment of, or plan to, address client #4's refusals to participate in training. There was no plan to address Client #6's constant movement that interfered with training.	W 196			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 196	<p>Continued From page 22</p> <p>Client #7 had a training program repeatedly implemented incorrectly, or not implemented at all, and lack of training programs that would occupy most of his day. This failure resulted in Clients' primary opportunity to learn being missed because of the facility's dysfunction within the Active Treatment loop.</p> <p>Findings included ...</p> <p>Record review of Client #1's Individual Habilitation Plan (IHP), dated 09/12/19, showed two long-range goals:</p> <ol style="list-style-type: none"> 1. Client #1 would live in the least restrictive environment where she is safe and active. 2. Provide Client #1 with a supportive setting to enable her to learn greater independence in daily living skills. <p>Client #1's training programs to achieve the two long-range goals were as follows:</p> <ul style="list-style-type: none"> Learn to wash her legs Cut her food Open her purse Wear a robe after showering Close the microwave Apply toothpaste to her toothbrush Engage in fewer behaviors Use existing communication to communicate a request or refusal <p>Observation at 301 House on 10/08/19 at 7:41 AM showed Client #1 sat in the TV room and looked at a magazine. At 7:50 AM, Client #1 went to the bathroom. At 7:54 AM, Direct Care Staff (DCS) asked Client #1 if she wanted to color.</p>	W 196		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 196	<p>Continued From page 23</p> <p>Client #1 scribbled on blank pieces of paper until 8:19 AM when DCS assisted her to a chair in the TV room and handed her a magazine. At 8:51 AM, Client #1 went to her room to get her coat to leave for the Activity Building. At 9:00 AM, Client #1 took her medication and then left the house at 9:21 AM. During this observation, the surveyor did not observe any training, including training for her identified goals.</p> <p>Observation at the Activity Building on 10/08/19 from 9:47 AM-10:42 AM showed Client #1 sat at a table covered with white paper. The paper had various hand drawn outlines of flowers on it and staff asked Client #1 if she wanted to paint. Staff Y, Attendant Counselor (AC), poured paint into a small container. Client #1 dipped a paintbrush in paint and applied it to the paper. She did not attempt to paint the flowers drawn on the paper and Staff Y did not cue her to paint the flowers. Client #1 covered the lower section of the paper and the side of the table with paint. Staff Y then brought a container of large beads to Client #1. Client #1 placed beads on a string that Staff Y held. Approximately seven minutes later, Staff Y and Client #1 got a box labeled "nuts and bolts." For approximately four minutes they sat at the table attempting to put nuts on the bolts, however, the nuts were too small to fit on the bolts. Staff Y then brought two books to Client #1 and they thumbed through them. At 10:18 AM, Staff Y asked another staff in the room, "Am I supposed to be doing anything?" and they responded that Client #1 should be in the gym working on fine and gross motor skills. At 10:22 AM, Staff Y left and an Adult Training Specialist (ATS) sat beside Client #1. For approximately 10 minutes, Client #1 placed small plastic tubes on a</p>	W 196		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 196	<p>Continued From page 24</p> <p>tray. At 10:32 AM, the ATS brought a container of fake flowers to Client #1 and a piece of foam to stick the flowers in to make a bouquet. Client #1 handed flowers to the ATS and the staff placed them in the foam to create the bouquet. During this observation, the surveyor did not observe any training, including training for her identified goals.</p> <p>During an interview on 10/08/19 at 10:42 AM, Staff Z, ATS, stated that Client #1 was working on fine motor skills, movement, making choices and choosing what she wanted to do. Staff Z stated that Client #1 was also learning to interact with others.</p> <p>Observation at 301 House on 10/08/19 at 1:47 PM showed Client #1 and another Client sat at a table in the TV room. Staff Y, AC, stated to the surveyor, "These two are relaxing." Client #1 attempted to put together a 4 piece wooden puzzle. At 2:24 PM, staff assisted Client #1 to a chair in front of the TV and staff turned the TV on. Client #1 sat in the chair, head down, eyes closed, until 3:16 PM. During this observation, the surveyor did not observe any training, including training for her identified goals.</p> <p>Observation at the Activity Building on 10/09/19 from 11:29 AM-12:14 PM showed staff served all Clients their meals and staff cut Client #1's food for her. Staff added gravy to Client #1's meal after Client #1 shook her head "no" when staff asked if she wanted gravy. During this observation, the surveyor did not observe any</p>			W 196			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 196	<p>Continued From page 25 training, including training for her identified goals.</p> <p>Record review of Client #1's training program for cutting her food, started September 1, 2018, showed staff were to prompt her to pick up her knife, ask her if she had tried to cut her food, and assist her if necessary.</p> <p>Observation at 301 House on 10/09/19 at 4:10 PM showed Client #1 sat at the dining room table with a pumpkin sitting in front of her. Client #1 was using long, broad strokes to cover the pumpkin in paint. At 4:16 PM, Client #1 began covering the paper on the table with paint. Client #1 rubbed the paintbrush on the paper covering the paper with paint, and did not have obvious intent to her action. Staff stated that Client #1 was participating in "art." At 4:39 PM, staff walked with Client #1 to the TV room where they sat at a table and looked at a magazine. At 5:03 PM, Client #1 ate dinner, rinsed her dishes, and put them in the dish sanitizer independently. At 5:36 PM, Client #1 returned to the TV room and sat at the table where she sat until 6:15 PM, scribbling on blank pieces of paper, taking markers out of the box and then replacing them. During this observation, the surveyor did not observe any training, including training for her identified goals.</p> <p>During an interview on 10/10/19 at 10:10 AM, Staff P, QIDP stated that Client #1's IHP was current.</p>			W 196			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 196	<p>Continued From page 26 Client #4</p> <p>Record review on 10/07/19 of Client #4's IHP Revision, dated 10/01/19, showed the following programs:</p> <p>Walk one length of the field; Put money in his wallet; Put a shirt on a clothes hanger; Close his bedroom door when changing; Wash his hands; and Stop at the curb before crossing the street.</p> <p>Observation on 10/08/19 in House 316 showed:</p> <p>7:26 AM - 8:26 AM Client #4 entered the living room and sat in a recliner. No training occurred. At 8:42 AM, a DCS walked with Client #4 into the bathroom and shaved his face and neck with an electric razor. No training on shaving occurred. When asked, the DCS stated that there was no training on shaving because Client #4 would not do it. At 9:04 AM - 9:31 AM, Client #4 sat in a recliner. A DCS spoke to him for a few seconds. When the DCS got no response from Client #4, the DCS walked away. No training observed.</p> <p>Observation on 10/08/19, in the Vocational room at the Activity Building from 1:43 PM - 2:45 PM, showed Client #4 shredded paper. An ATS implemented a vocational training program to place a bag of shredded paper on the scale one time. The training lasted from 2:28 PM - 2:35 PM. The ATS did the task as he tried to hold Client #4's hand on the bag.</p>	W 196		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 196	<p>Continued From page 27</p> <p>Observation on 10/08/19 in House 316 at 2:57 PM - 3:12 PM showed Client #4 entered the house from work. He put his coat in his room, went to the kitchen, and took a carton from the refrigerator. Staff noticed and took the carton away from him and told him to wait until later. Client #4 then went into the living room and sat in his recliner. No training occurred.</p> <p>Observation on 10/08/19 from 3:12 PM - 3:20 PM in House 316 showed Client #4 had an opportunity for training when he took his meds. He refused to participate in his self-administration medication training program and the nurse accepted his refusal, which resulted in no training.</p> <p>Observation on 10/08/19 from 3:20 PM - 4:00 PM showed opportunities for training during Client #4's trip to the fiscal office and Coffee Shop with a DCS. At the fiscal office, Client #4 received \$2.00. The DCS did not implement Client #4's money management program (put money in wallet) and no training occurred. After receiving the money, they went to the Coffee Shop to spend the money. No training occurred regarding traffic safety when crossing the street both to and from the Coffee Shop. Upon return to the house, the DCS broke up the cookies Client #4 purchased at the Coffee Shop and gave them to him to eat. No training occurred to teach him to make bite size pieces of his food as required by his diet order.</p>	W 196		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 196	<p>Continued From page 28</p> <p>Observation on 10/09/19 in House 316 from 5:08 PM - 6:05 PM showed Client #4 finished his dinner, sat in a recliner, put on pajamas, took his meds, and went to his room. No training observed.</p> <p>Record review of Client #4's IHP, dated 12/17/18, showed, "[Client #4's first name] continues to refuse the vast majority of activities offered to him." There were no training programs to address Client #4's continued refusals to participate in training.</p> <p>During an interview on 10/10/19 at 8:15 AM, Staff C, QIDP, Staff I, QIDP, Staff J, Attendant Counselor Manager (ACM) and Staff K, Psychologist 3, acknowledged the IHP and the IHP Revision mentioned above were current. They stated that staff were to implement training at every opportunity, Client #4 sat in his recliner most of the time, and he did not like to do anything.</p> <p>Client #6</p> <p>Record review Client #6's IHP, dated 06/25/19, showed:</p> <p>Her current training programs were to place a dollar bill into her purse, stop at the crosswalk, lower her own pants in the bathroom (to use the toilet), grasp her toothbrush, and communicate her wants/needs/refusals by leading staff by the hand to show them what she needed/wanted.</p>	W 196		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 196	<p>Continued From page 29</p> <p>Observation on 10/08/19 in House 315/316 showed:</p> <p>At 8:20 AM, a DCS woke up Client #6. The DCS walked with her to the bathroom where he washed Client #6's face and hands, brushed her teeth, wet her hair with a towel, brushed her hair, washed her feet, put deodorant on her, put her bra and shirt on her, brushed her hair again, put lotion on her feet, put on her socks, underwear, pants, and shoes. He then had her stand up and he put an incontinent brief on her and pulled up her clothes. No training occurred.</p> <p>At 8:26 AM, the nurse fed Client #6 her medications already mixed in applesauce. Client #6 quickly swallowed the medications as the nurse spooned them into her mouth. This took less than a minute. She then walked constantly around the house. No training occurred.</p> <p>At 8:47 AM, Client #6 sat at the dining room table alone and independently ate her breakfast. At 8:53 AM, she stood up from the table and started to leave the dining room. A staff blocked her way and washed her hands with a damp cloth then allowed her to exit the dining room. Another staff cleared her dishes from the table. No training occurred.</p> <p>From 8:53 AM - 9:30 AM, Client #6 walked around the house constantly. She picked up paper or coloring books and tore them, and picked up towels and placed them in her mouth. When staff said no or asked her what she had, she dropped the item on the floor and quickly</p>			W 196			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 196	<p>Continued From page 30 walked away. No training occurred.</p> <p>Observation on 10/08/19 in the Activity Building from 9:57 AM - 10:40 AM showed Client #6 walked around the art room, touched, and dropped items. Other times staff blocked her from getting items, and followed her around the room. Whenever the staff got close to her, she quickly walked away. The staff attempted to engage her with activities. Client #6 did not respond to the staff. No training occurred.</p> <p>Observation on 10/09/19 in House 315/316 showed:</p> <p>From 5:20 PM - 7:25 PM, Client #6 walked constantly around the house. She periodically picked up items. When staff approached or said her name, she dropped the items immediately and walked away very quickly. Staff watched where she was and redirected her to the main living areas of the house. No training occurred.</p> <p>From 7:28 PM - 7:47 PM, Client #6 took a shower. The staff washed, rinsed, and dried her. The staff put lotion on her hands and legs, put her nightgown and incontinent brief on her, brushed her hair, and put socks and slippers on her feet. Staff walked her to her room, helped her onto her bed, took off her slippers, covered her up with a blanket, and said good night. No training occurred.</p> <p>During an interview on 10/10/19 at 9:10 AM, Staff I, QIDP, Staff J, ACM, and Staff K, Psychologist</p>			W 196			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 196	<p>Continued From page 31</p> <p>3, stated that Client #6 was difficult to engage as she was in constant motion and there was no program to address this.</p> <p>Client #7</p> <p>Observation of Client #7 on 10/08/19 from 9:16 AM to 10:50 AM showed:</p> <p>at House 308 he finished a snack and got ready to go to Adult Programs;</p> <p>he arrived at the "Calm Room" in the 500 Building at 9:56 AM. After taking off his coat and backpack, he walked around the room and touched a couple of activities. Then he went into the bathroom at 9:58 AM. After coming out of the bathroom, he put on his coat and backpack and left the room at 10:01 AM; and</p> <p>he arrived at the Adult Training Programs building at 10:06 AM and went into the bathroom. He came out of the bathroom at 10:18 AM and went into the "Get Your Move On" room where he paced around. Each time a staff tried to have him do something, he became agitated (facial grimacing, noise making). At 10:32 AM, he went to the bathroom. At 10:38, he went back to the room for a short time, but then went back to the bathroom. He left the bathroom at 10:50 AM to go back to the room.</p> <p>No training was observed.</p> <p>Observation of Client #7 on 10/08/19 at House 308 from 1:53 PM to 2:55 PM showed:</p>	W 196			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 196	<p>Continued From page 32</p> <p>He spent time drinking water from the faucet by putting his mouth under the faucet. On one occasion staff told him to use a cup, but he didn't and staff did nothing further. On another occasion staff told him to use a cup and opened the drawer where the cups were kept, Client #7 became agitated and kept closing the drawer. Staff did nothing further and he continued to drink from the faucet. On two other occasions staff did not intervene when he drank from the faucet.</p> <p>Took the trash out with staff providing verbal and physical assistance as needed.</p> <p>Had a snack which he did with minimal assistance from staff.</p> <p>Spent time in the bathroom.</p> <p>No training according to the IHP was observed and the "Teaching Plan for: Appropriate Drinking Behavior" was implemented incorrectly (See W251 for details).</p> <p>Observation of Client #7 on 10/09/19 at house 308 from 1:20 PM to 1:45 PM showed:</p> <p>He spent time drinking water from the faucet by putting his mouth under the faucet. On one occasion, staff did not intervene. On three other occasions, the staff cued him to use a cup, but when he did not comply, they walked away.</p> <p>Went to his bedroom with staff to "see if it was clean." Two minutes later, he came out briefly and then went back into his bedroom. Six</p>			W 196			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 196	<p>Continued From page 33</p> <p>minutes later, he came out and staff cued him to wash his hands.</p> <p>No training according to the IHP was observed and the "Teaching Plan for: Appropriate Drinking Behavior" was implemented incorrectly (See W251 for details).</p> <p>Observation of Client #7 on 10/09/19 at House 308 from 6:25 PM to 7:00 PM showed:</p> <p>He drank water from the faucet by putting his mouth under the faucet on two occasions. Both times staff cued him to use a cup, but he got agitated and the staff did not follow up further.</p> <p>A staff cued him to get a laundry bag and he left and independently returned with the bag. Staff assisted him to get laundry and take it to the service hallway.</p> <p>Had a snack, which he did with minimal assistance from staff.</p> <p>No training to the IHP was observed and the "Teaching Plan for: Appropriate Drinking Behavior" was implemented incorrectly (See W251 for details).</p> <p>Review of Client #7's IHP, dated 07/31/19, showed the following training programs: Deodorant application, shaving, tooth brushing, self-medication, money management, laundry, his inappropriate behaviors, and the replacement</p>	W 196			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 196	Continued From page 34 behavior related to his inappropriate behaviors. Each of these programs were to be implemented in specific situations, would take only a short time to implement, and would not fill his day. During these observations Client #7 received no training according to his IHP, dated 07/31/19, and the "Teaching Plan for: Appropriate Drinking Behavior" for Client #7 was implemented incorrectly. During an interview on 10/10/19 at 9:00 AM, Staff V, QIDP, stated that the 07/31/19 IHP was current.			W 196			This document was prepared by Residential Care Services for the Locator website.
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to identify and address one of eight Sample Clients' (Client #4) consistent refusals to participate in his active treatment program. Client #4 refused to communicate and engage in training programs, activities, and tasks. This prevented him from learning anything. Findings included ...			W 214			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 214	<p>Continued From page 35</p> <p>Observation on 10/08/19 in House 316 showed:</p> <p>At 8:45 AM, staff asked Client #4 to clean out the razor after she shaved him. The staff attempted to assist the Client by placing her hand over his hand to get him to participate, but the staff ended up cleaning the razor. When asked, the Direct Care Staff stated that they did not do any training on shaving because Client #4 would not do it.</p> <p>At 9:30 AM, a staff asked Client #4 how he was doing as he sat in a recliner in the living room. He did not respond and the staff walked away.</p> <p>At 3:16 PM, the nurse asked Client #4 to take the pill cup (small cup with applesauce mixed with the pills) from her and take his pills. He did not move or respond so the nurse fed him his medications. She stated that he usually did not feed himself his medications.</p> <p>Observation on 10/08/19 at 3:24 PM showed Client #4 left House 316 with a staff to get money from the fiscal office. Client #4 did not carry his paperwork to request money. The staff stated that he would not do it. At the fiscal office, the staff turned the paper in for Client #4, got \$2.00 for him, and placed it in an envelope for him. The staff stated he would not do it. They then went to the Coffee Shop to spend the money. The staff asked Client #4 to make a choice. He stood and looked into the drink vending machine and did not respond to repeated questions from the staff about what he wanted. The staff was unable to tell which drink he was looking at. The staff stated that she would get him a root beer because she knew he liked that. She then realized the machine was not working. They</p>	W 214		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 214	<p>Continued From page 36</p> <p>moved to the snack vending machine. She asked him repeatedly what he wanted and when he did not respond, she purchased the cookies she stated that she knew he liked. When crossing the street to and from the Coffee Shop, the staff asked Client #4 to stop and wait for her at the curb. He did not do this. Upon return to House 316 at 3:45 PM, the staff broke his cookies into bite size pieces. When asked, she stated that Client #4 could probably break up his own cookies, but he would just eat them instead of breaking them into pieces like his diet directed.</p> <p>Record review of a Communication Assessment, dated 11/16/18, for Client #4 showed, "[Client #4's first name] sometimes imprecisely signs 'pop or please' but mostly needs cueing to sign and seems annoyed by the demand."</p> <p>Record review of Client #4's Positive Behavior Support Plan, dated 12/17/18, showed he preferred to spend his time in a chair watching others and he might refuse to comply with unwanted requests from staff. There was no functional assessment for why Client #4 refused to participate in training and no plan for this behavior.</p> <p>Record review of Client #4's Individual Habilitation Plan, dated 12/17/18, showed:</p> <p>He refused the vast majority of activities offered to him.</p> <p>He preferred to spend his leisure time sitting in a chair watching others.</p> <p>Spent more time observing rather than</p>			W 214			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 214	Continued From page 37 interacting with others. Required hand-over-hand assistance with grooming tasks due mostly to his reluctance to participate in the tasks, not his skill level. He knew a few signs (from American Sign Language) but did not like to use them. The team discontinued a shaving program this year due to his frequent refusal to participate. There was no function identified for Client #4's refusals to participate in training and no plan to address it. During an interview on 10/10/19 at 8:15 PM, Staff C, Qualified Intellectual Disability Professional (QIDP), Staff Q, QIDP, Staff J, Attendant Counselor Manager, and Staff K, Psychologist 3, stated that Client #4's refusal to participate got in the way of training and needed to be addressed.			W 214			This document was prepared by Residential Care Services for the Locator website.
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to write training objectives for identified needs for three of eight Sample Clients (Clients #6, #7, and #8). Client #6 had no objective or program to address her			W 227			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 227	<p>Continued From page 38</p> <p>constant movement that prevented training. Client #7 had no objective or training to address his refusals to participate in treatment when asked. Client #8 had no objective or training that addressed learning to bathe himself. As a result, Clients #6 and #7 had pervasive problem behaviors that interfered with their training; Client #8 could learn to bathe himself and was not receiving this training. The facility identified these needs but did not address them with training programs. The identified behaviors of Clients #6 and #7 are major obstacles that consistently get in the way of all training attempts, and unless the facility addresses these behaviors, they will continue to prevent the Clients from learning skills. Client #8 will remain dependent on staff for assistance bathing due to the lack of training.</p> <p>Findings included ...</p> <p>Client #6 Observation on 10/08/19 in House 315/316 from 8:39 AM - 9:31 AM showed Client #6 walked constantly throughout the house. When she was done eating breakfast she left the dining room and continued to walk around the house. A Direct Care Staff (DCS) brushed her hair while she walked in the living room. No training observed.</p> <p>Observation on 10/08/19 in the Activity Building from 9:57 AM - 10:40 AM showed Client #6 walked continuously around the art room, sometimes touching items. A DCS followed her and asked her to engage in activities. Client #6 did not respond to the DCS, did not engage in any activity, and continued constantly walking quickly around the area. The DCS did not address her lack of engagement in the offered</p>	W 227		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 227	<p>Continued From page 39 activities.</p> <p>Observation on 10/09/19 in House 315/316 from 5:08 PM - 7:51 PM showed:</p> <p>Client #6 constantly walked around the house. She took a coloring book from another Client, ripped the cover, and used the torn piece to wrap around her finger. She also picked up cloths and put them in her mouth.</p> <p>A DCS showered her. Client #6 did not follow requests from the DCS to assist in the process.</p> <p>Record review of a Psychiatry Consultation, dated 08/07/19, for Client #6 showed:</p> <p>Client #6 exhibited extreme motor hyperactivity as a child.</p> <p>She had difficulty slowing herself down and staying focused on a given task.</p> <p>Client #6 had a high level of energy, continued movement even when extremely tired, and staff needed to encourage her to relax.</p> <p>"It is notable that she continues to be very restless and hyperactive with difficulty sitting still and paying attention in order to participate in any activities."</p> <p>"Restlessness, hyperactivity, and poor attention are affecting her ability to participate in treatment and activities of daytime living."</p> <p>Record review of an Occupational Therapy Evaluation, dated 06/03/19, for Client #6 showed</p>			W 227			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 227	<p>Continued From page 40</p> <p>she paced for long periods of time, and could display hyperactivity and impulsiveness during dining.</p> <p>Record review of a Communication Assessment, dated 06/06/19, for Client #6 showed she had difficulty sustaining attention due to her constant need for movement. This need for excessive movement interfered with communication. She mostly walked around the house and it was rare to see her sit down or be still.</p> <p>Record review of the Positive Behavior Support Plan, dated 06/29/19, for Client #6 showed it was quite difficult for her to stay on task, maintain focused attention, and she was easily distracted. She liked to walk around the house or Adult Programs, and going where she pleased. She tended to be in constant motion and paced her environments. The directions for staff did not show instructions to staff to address her constant movement.</p> <p>Record review of an Individual Habilitation Plan (IHP), dated 06/25/19, for Client #6 showed that sustaining attention was difficult for her due to her need for constant movement. She became easily stimulated, very active, full of energy, and walked away from others quickly. There was no objective or behavior management plan to address her constant movement and lack of ability to focus.</p> <p>Record review of QIDP (Qualified Intellectual Disability Professional) Review (analysis and summary of progress in active treatment), dated 10/07/19, for Client #6 showed:</p>	W 227		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 227	<p>Continued From page 41</p> <p>She was difficult to engage in tasks due to her restlessness and difficulty remaining in any one location.</p> <p>An Adult Training Specialist reported Client #6 was extremely difficult to engage in any adult program classroom due to her restlessness and apparent inability to remain in any one location for long. She frequently went on long walks while at the Adult Program.</p> <p>"She seems to leave supervision just to explore as she seems restless, but not agitated. Staff take her for long walks and this helps her to be less hyperactive and restless."</p> <p>During an interview on 10/10/19 at 9:15 AM, Staff I, QIDP, Staff J, Attendant Counselor Manager, and Staff K, Psychologist 3, stated that Client #6 was on psychotropic medication to address her lack of ability to focus. They also stated that the IHP did not address behavioral options to address this need. They stated that it was very difficult to do training with Client #6 when she would not be still. This identified barrier needed to be addressed in order to be effective with active treatment.</p> <p>Client #7 Review of Client #7's IHP, dated 07/31/19, contained the following statement: "If he does not wish to engage in the task that staff are introducing him to, he will often begin to engage in challenging behaviors such as SIB [self-injurious behavior] (typically hitting his ears and head repeatedly)."</p> <p>Observation on 10/08/19 at 10:18 AM in the "Get</p>	W 227		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 227	<p>Continued From page 42</p> <p>Your Move On" room in Adult Training Program building showed staff tried to get Client #7 to pick up recreation balls and put them in a specific place on three separate occasions. Each time he refused and made vocalizations and displayed body language of agitation as evidenced by turning quickly towards the staff with a threatening body posture, tensing the muscles of his upper body, scrunching up his face, and making a loud noise.</p> <p>During an interview on 10/08/19 at 2:05 PM, DCS stated that Client #7 did what he wanted to do, when he wanted to do it, and got agitated if told to do something he did not want to do at that time.</p> <p>Review of Client #7's IHP, dated 07/31/19, showed there was no training program for how to teach Client #7 new tasks or to gain his cooperation with doing tasks when needed.</p> <p>Client #8 Review of Client #8's Comprehensive Functional Assessment of Direct Care Independent Living Skills, dated 11/20/18, showed the following statement in the Bathing section: "[Client #8's initials] when on his own will not take soap, etc. w/ [with] him and will just stand under the water. [Client #8's initials] prefers help from familiar staff ..."</p> <p>Review of Client #8's IHP, dated 12/05/18, showed no training program for learning to bathe independently.</p> <p>During an interview on 10/10/19 at 9:00 AM, Staff V, QIDP, stated that there was no bathing</p>			W 227			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 227	Continued From page 43 program for Client #8.			W 227			This document was prepared by Residential Care Services for the Locator website.
W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to write a training program that identified how often, and for how long, one of eight Sample Clients (Client #5) sweeping program identified how many times he successfully completed having his hand placed on the broom handle before he was determined to have learned the skill being taught. Findings included ... Record review of Client #5's Sweeping Program showed, "Objective: [Client #5's first name] will Holds (sic) the broom with one hand in the middle of the broom handle, and one hand towards the top of the broom handle (Step 1) with hand over hand support by 11/31/19." It did not indicate how many times or for how long he must complete the objective to be successful. During an interview on 10/10/19 at 9:10 AM, Staff C, Qualified Intellectual Disability Professional, stated that the program should have had criteria to determine when the Client learned the skill, but it did not.			W 231			
W 234	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i)			W 234			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 234	<p>Continued From page 44</p> <p>Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that teaching plans contained clear and detailed instructions for staff to implement them correctly and consistently for two of eight Sample Clients (Clients #2 and #5). Client #2 had a teaching program for bathroom privacy that had insufficient, detailed instructions for staff to implement. Client #2 also had a money program and a room cleaning program with instructions that did not match the stated objective. Client #5 had a shower program, which gave instructions for staff to provide prompts, and how to reinforce the appropriate action, but they did not match the stated objective. This resulted in staff not really knowing how and what to teach the Clients.</p> <p>Findings included ...</p> <p>Client #2</p> <p>1. Record review of Client #2's file showed a teaching plan for Bathroom Privacy with the objective, "[Client #2's first name] will shut the bathroom door independently (step 4) for 85% of the time for 2 consecutive months by 12/32/19." Step one showed, "Wait for [Client #2's first name] to shut the door on his own." It was unclear if this meant when Client #2 started to shut the door or when he was finished shutting the door. Step two showed, "Once [Client #2's first name] has started to shut the bathroom door,</p>	W 234		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 234	<p>Continued From page 45</p> <p>provide verbal reinforcement by saying, "great job shutting the bathroom door!" Staff were to provide positive reinforcement to the Client before he completed the objective of closing the door.</p> <p>2. Record review of Client #2's file showed a teaching plan for Money Denominations with the objective, "[Client #2's first name] will count out 5 pennies to make 1 nickel (step 1) with 1 verbal and 1 gestural prompt..." The objective required Client #2 to count pennies. The instructions within the program showed Client #2 was to say "One Nickel," not count pennies. Further, instructions to staff were to provide verbal reinforcement to Client #2 for saying, "One Nickel," not for counting pennies.</p> <p>3. Record review of Client #2's file showed a teaching plan for Room Cleaning with the objective, "[Client #2's first name] will grasp mop from mop wringer (step 4) with physical prompt ..." The objective was to grasp the mop but there was no description of the physical prompt staff would use. The instructions within the program were mostly related to mopping the floor; not grasping the mop. Further, staff were instructed to provide verbal reinforcement when Client #2 mopped the floor, not when he grasped the mop.</p> <p>During an interview on 10/09/19 at 3:57 PM, Staff C, QIDP, when showed the issues within the Bathroom Privacy, Money Denominations, and Room teaching programs, stated that the teaching plans had unclear instructions.</p>			W 234			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 234	Continued From page 46 Client #5 Record review of Client #5's Individual Habilitation Plan (IHP), dated 08/07/19, showed a shower program with an objective for him to rinse his hair with one verbal prompt and visual prompt. The instructions for staff showed: "Provide 1 verbal prompt, saying "rinse your back, [Client #5's first name]" and provide a visual prompt by pointing to the "back" visual of the bathing sequence (a picture of a back located on the wall just outside the shower area). Once [Client #5's first name] has dried his back, provide verbal reinforcing, saying, "great job drying your back, [Client #5's first name]." Client #5 was to rinse his back but staff reinforced the action of him drying his back. During an interview on 10/10/19 at 9:10 AM, Staff C, QIDP, agreed that the verbal prompt and visual prompt to initiate the teaching program and the instructions for reinforcing the teaching program did not match the objective listed.			W 234			This document was prepared by Residential Care Services for the Locator website.
W 239	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(vi) Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.			W 239			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 239	<p>Continued From page 47</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide training for a Client to use replacement behaviors instead of using inappropriate behaviors for one of eight Sample Clients (Client #3). Client #3's assessments showed that they had communications skills to replace her current inappropriate behavior, but she did not use them. This caused the Client's inappropriate behaviors to continue and prevented her from improving her social skills.</p> <p>Findings included ...</p> <p>Client #3</p> <p>Record review of Client #3's Positive Behavior Support Plan (PBSP) and PBSP: Directions for Staff, both dated 05/22/19, showed there was no training program to teach Client #3 an appropriate replacement behavior for her inappropriate behavior.</p> <p>During an interview on 10/09/19 at 10:00 AM, Staff H, Psychology Associate, stated that Client #3 did not have a training program for a replacement behavior as she had a skill to replace inappropriate behavior, but failed to use it effectively.</p>			W 239			This document was prepared by Residential Care Services for the Locator website.
W 247	<p>INDIVIDUAL PROGRAM PLAN</p> <p>CFR(s): 483.440(c)(6)(vi)</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to allow one of eight</p>			W 247			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 247	<p>Continued From page 48</p> <p>Sample Clients (Client #1) to choose whether or not she wanted gravy on her lunch when staff poured gravy on her meal after Client #1 shook her head no. This resulted in Client #1 not having her choice honored and showed her that staff would over-rule her decisions.</p> <p>Findings included ...</p> <p>Observation at the Activity Building on 10/09/19 at 11:36 AM showed Staff S, Adult Training Staff, asked Client #1 if she wanted gravy on her meal of ground meat, potatoes, and green beans. Client #1 shook her head no two times. Staff S stated, "A little bit?" and Client #1 shook her head no again. Staff S poured gravy over the meat, potatoes, and green beans. Client #1 ate what staff provided for the meal.</p> <p>Record review of Client #1's lunch ticket, dated 10/09/19, showed Client #1 did not require gravy or other condiments to moisten her food.</p> <p>During an interview on 10/09/19 at 12:09 PM, when asked if Client #1 required gravy on her lunch, Staff R, Attendant Counselor, stated, "She needs gravy to loosen it." Staff R stated that staff used milk at breakfast to moisten the food prior to Client #1 eating it.</p>			W 247			This document was prepared by Residential Care Services for the Locator website.
W 249	<p>PROGRAM IMPLEMENTATION</p> <p>CFR(s): 483.440(d)(1)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the</p>			W 249			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 249	<p>Continued From page 49</p> <p>objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide continuous training for three of eight Sample Clients (Clients #1, #4, and #5). These three Clients had training programs that staff did not implement when the opportunity arose. Staff did not implement Client #1's dining program during lunch. Staff did not implement Client #4's money management program or his safety program while crossing a street. Staff did not implement Client #5's rinse in the shower program. These missed training opportunities resulted in a lack of training for the Clients, and prevented them from learning as quickly as possible.</p> <p>Findings included ...</p> <p>Client #1</p> <p>Record review of Client #1's current training program for cutting food, dated September 2019, showed Client #1 was to pick up her knife during dinner and cut one item into four pieces.</p> <p>Observation at the Activity Building on 10/09/19 at 11:42 AM showed Staff R, Attendant Counselor (AC), used a knife to cut potato wedges and meat that was on Client #1's plate. Staff R did not implement the training plan to have Client #1 cut her own food. At 11:49 AM, Staff R took the spoon Client #1 was eating with and "cut" some meat into smaller pieces.</p>	W 249		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 249	<p>Continued From page 50</p> <p>During an interview on 10/09/19 at 12:02 PM, when asked if Client #1 had a training program to cut her own food, Staff R stated, "No. She just needs it cut smaller." When asked if Staff R routinely worked with Client #1, they stated that they routinely worked at House 301 where Client #1 lived.</p> <p>Client #4</p> <p>Record review of Client #4's IHP Revision, dated 10/01/19, showed he had training programs to put his money in his wallet and to stop on the curb at a crosswalk.</p> <p>Observation on 10/08/19 from 3:20 PM - 4:00 PM showed Client #4 left House 316 and went to the fiscal office and Coffee Shop with Staff U, AC, and two other Clients. Client #4 received \$2.00 that Staff U put into a plain white envelope. Staff U did not implement Client #4's money management program. The group then headed to the Coffee Shop that required crossing a street. Staff U did not implement Client #4's traffic safety program and he did not stop on the curb before crossing the street both to and from the Coffee Shop.</p> <p>During an interview on 10/08/19 at 3:59 PM, Staff U stated that she was supposed to have Client #4 stop at the crosswalk and look both ways.</p> <p>During an interview on 10/10/19 at 8:15 AM, Staff Q, Qualified Intellectual Disability Professional, Staff J, Attendant Counselor Manager (ACM), and Staff K, Psychologist 3, stated that they expect staff to implement training programs at</p>			W 249			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 249	<p>Continued From page 51 every opportunity and the IHP revision above was current.</p> <p>Client #5</p> <p>Record review of Client #5's Rinse in Shower program, dated October 2019, showed:</p> <p>1. Materials needed were shampoo, soap, running shower water, and the sequence picture board on the wall of the shower area.</p> <p>2. Instructions for staff were to provide one verbal prompt by saying, "rinse your back, [Client #5's first name]," and provide a visual prompt by pointing to the picture of a person's back on the wall in the bathroom.</p> <p>Observation on 10/09/19 at 318 House at 6:18 PM, a Direct Care Staff (DCS) working with Client #5 asked the ACM if Client #5 could independently shower himself. The ACM shook her head no and offered no further instruction. The DCS verbally cued Client #5 to grab a towel from a cabinet. The DCS and Client #5 then went into the shower area and turned on the water and the DCS pulled the privacy curtain and verbally cued Client #5 to get into the shower. After two minutes, the DCS realized they did not have Client #5's grooming bin with his shampoo and soap, came out of the shower area, and retrieved it. The DCS did not have the correct materials to implement the program when Client #5 began showering, and did not use the correct prompts to initiate the training.</p> <p>During an interview on 10/10/19 at 9:10 AM, Staff</p>			W 249			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 249	Continued From page 52 C, QIDP, stated that Client #5's shower program was the current program staff should be running. Staff A Attendant Counselor Manager, stated that the formal program was implemented in the mornings. Staff A was not aware that staff should implement the program whenever Client #5 chose to shower.			W 249			This document was prepared by Residential Care Services for the Locator website.
W 250	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update the Active Treatment Schedule to reflect the current Individual Habilitation Plan (IHP) for one of eight Sample Clients (Client #2). Client #2's Active Treatment Schedule was 14 months old and did not reflect: changes to his prioritized needs; changes to his level of supervision; or the discontinuation of a training program as written in his current IHP. This prevented facility staff from knowing when and where to implement his training plans. Findings included ... Prioritized needs: Review of Client #2's file showed an IHP, dated			W 250			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 250	<p>Continued From page 53</p> <p>04/03/19, with prioritized needs in the areas of keeping his living environment sanitary and clean, to communicate his needs more independently, to increase his attention span on a given activity, to increase his bathing skills, and to increase his vocational reliability. The Active Treatment Schedule, dated 03/29/18, did not contain this current information.</p> <p>Supervision level:</p> <p>Review of Client #2's file showed an IHP Revision, dated 05/17/19, with a change to Client #2's supervision level from 1:1 (one staff to supervise one Client) at arm's reach from 6:30 AM to 9:00 PM and a shared supervision from 9:00 PM to 6:30 AM, to 1:1 arms reach 6:30 AM to 7:00 PM and on shared supervision from 7:00 PM to 6:30 AM. The Active Treatment Schedule, dated 03/29/18, did not reflect this current information.</p> <p>Training programs:</p> <p>Review of Client #2's file showed an IHP Revision, dated 09/01/19, showed Client #2's formal program for Traffic Safety was discontinued. The Active Treatment Schedule, dated 03/29/18, did not contain this current information.</p> <p>During an interview on 10/09/19 at 3:57 PM, Staff C, Qualified Intellectual Disability Professional,</p>			W 250			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 250	Continued From page 54 stated that Client #2's Active Treatment Schedule, dated 03/29/18, was not a current schedule.			W 250			This document was prepared by Residential Care Services for the Locator website.
W 251	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement training program plans as written for three of eight Sample Clients (Clients #2, #5, and #7). Staff did not implement Client #2's boot scraping and the communication of a choice programs correctly. Staff did not implement Client #5's shower program correctly. Staff did not implement Client #7's program to learn to use a cup, instead of drinking from the faucet, correctly. Because of staff not consistently teaching Clients their programs, the Clients did not learn the identified skills. Findings included ... Client #2 1. Record review of Client #2's teaching plan			W 251			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 251	<p>Continued From page 55</p> <p>showed he had a plan to learn how to use a boot scraper. Staff were to stand near the boot scraper and provide the verbal prompt, "[Client #2's first name], wipe your feet 4 times, please!" Staff were to count as Client #2 did this.</p> <p>Observation on 10/08/19 at 9:51 AM at the Adult Training Building, showed Client #2 and Staff M, Adult Training Specialist (ATS) 2, stood at the boot scraper. Staff M stated, "Go ahead, I know you know. Go ahead and wipe your feet. One more time. Wipe them off clean." Staff did not give the verbal cue, "[Client #2's first name], wipe your feet 4 times, please!"</p> <p>During an interview on 10/08/19 at 10:05 AM, Staff M, ATS 2, stated that she did not give the verbal prompt as written in the teaching plan.</p> <p>2. Record review of Client #2's teaching plan showed he had a plan to communicate his choice of an activity by pointing to one of two pictures presented to him. Staff were to select two pictures of activities from Client #2's Communication Book that he might like to do at that time. Staff would then place the two pictures on the Velcro on the front of the book, approach Client #2 with the book showing the choices in front of him, and say, "[Client #2's first name], what would you like to do, ____ or ____?" Staff were to wait for Client #2 to point to an activity.</p> <p>Observation on 10/08/19 at 3:25 PM at 317 House showed a Direct Care Staff (DCS) asked</p>	W 251		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 251	<p>Continued From page 56</p> <p>Client #2 if he wanted to go to the Coffee Shop for social hour. DCS did not have Client #2's Communication Book, did not present two pictures, nor did he provide the verbal cue when he asked Client #2 if he wanted to go to the Coffee Shop for social hour. Another staff gave the DCS Client #2's communication book. The DCS opened the communication book and asked Client #2 what he would like to do, pointed to one picture, and then asked if he would like to go for a walk. DCS did not present two pictures, nor did he provide the verbal cue when he asked Client #2 if he wanted to go for a walk. The DCS then asked Client #2 if he would like to go for a walk, do laundry, listen to music, or go to social hour. DCS did not present two pictures, nor did he provide the verbal cue when he asked Client #2 if he wanted to go for a walk, do laundry, listen to music, or go to social hour.</p> <p>During an interview on 10/10/19 at 10:45 AM, Staff C, Qualified Intellectual Disability Professional (QIDP), stated that this was the current program.</p> <p>Client #5</p> <p>Record review of Client #5's Rinse in Shower program, dated October 2019, showed:</p> <ol style="list-style-type: none"> 1. Materials needed were shampoo, soap, running shower water, and the sequence picture board on the wall of the shower area. 2. Instructions for staff to provide one verbal prompt, was saying, "rinse your back, [Client #5's first name]," and provide a visual prompt by 	W 251		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 251	<p>Continued From page 57</p> <p>pointing to the "back" (a picture of a person's back) visual of the bathing sequence picture board on the wall in the bathroom.</p> <p>Observation on 10/09/19 at 318 House at 6:18 PM showed DCS working with Client #5 asked the Attendant Counselor Manager (ACM) if Client #5 could independently shower himself. The ACM shook her head no and offered no further instruction. The DCS verbally cued Client #5 to grab a towel from a cabinet. The DCS and Client #5 then went into the shower area and turned on the water and the DCS pulled the privacy curtain and verbally cued Client #5 to get into the shower. After two minutes, the DCS realized they did not have Client #5's grooming bin with his shampoo and soap, came out of the shower area, and retrieved it. The DCS did not use have the correct materials to implement the program when Client #5 began showering and did not use the correct prompts.</p> <p>During an interview on 10/10/19 at 9:10 AM, Staff C, QIDP, stated that Client #5's shower program was the current program staff should implement.</p> <p>Client #7</p> <p>Record review of Client #7's "Teaching Plan for: Appropriate Drinking Behavior" showed the following actions for staff to use.</p> <p>Cue Client #7 to use a cup if he drank directly from the faucet.</p>			W 251			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 251	<p>Continued From page 58</p> <p>If he did not follow the above direction, staff were to cue him again and point to the drawer with the cups.</p> <p>If he did not follow the above direction then, staff were to open the drawer to show the cups.</p> <p>If he still did not respond by using the cup to drink, staff were to cue him every "5 seconds" until he used the cup or stopped drinking from the faucet.</p> <p>Observation on 10/08/19 at House 308 showed Client #7 drank from the faucet:</p> <p>at 9:16 AM DCS told him to use the cup, but he did not. Staff did nothing further. He continued to drink from the faucet.</p> <p>at 1:53 PM DCS told him to use the cup and opened the cup drawer. Client #7 did not use the cup, became agitated (facial grimacing, noise making) and kept closing the drawer. Staff did nothing further. He continued to drink from the faucet.</p> <p>at 2:14 PM Professional staff and DCS did not intervene.</p> <p>at 2:34 PM DCS did not intervene.</p>	W 251		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 251	Continued From page 59 Observation on 10/09/19 at House 308 showed Client #7 drank from the faucet: at 1:20 PM a DCS did not intervene. at 1:33 PM DCS did not say anything but opened the cup drawer. DCS then cued him to use the cup but Client #7 pushed them away and DCS said, "Okay," and walked away. Upon returning to the faucet and drinking directly from it, the DCS again cued him to use the cup, and when Client #7 got agitated, said, "Okay," and walked away. Upon returning to the faucet and drinking directly from it, the DCS cued him to use a cup, Client #7 pushed them away, and the staff walked away. He continued to drink from the faucet. at 6:25 PM and DCS cued Client #7 to use a cup. Client #7 got agitated, the staff walked away, and he continued to drink from the faucet. at 6:52 PM and the DCS did not intervene. During an interview on 10/10/19 at 9:00 AM, Staff V, QIDP, stated that the "Teaching Plan for: Appropriate Drinking Behavior" in Client #7's file, with a start date of 08/01/19, was current.			W 251			This document was prepared by Residential Care Services for the Locator website.
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria			W 252			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A				STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155			
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W 252	<p>Continued From page 60</p> <p>specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff documented data to show that they implemented programs for three of eight Sample Clients (Clients #2, #5, and #6). Staff did not collect data for six skill acquisition programs as required for Client #2. Staff did not collect data for an entire month for most of Client #5's programs. Staff did not collect data for 15-minute safety monitoring for Client #6 as required. This prevented the facility from knowing if programs were implemented, and if they were not implemented, the reason why it was not implemented. The facility did not know how the Clients participated, if they had participated, or if the training/safety monitoring had even occurred. This prevented the facility from correctly analyzing the programs to determine if the facility needed to update or revise the programs to meet Client needs; and the facility could not account for Client #6's safety for all times.</p> <p>Findings included ...</p> <p>Client #2</p> <p>Record review of Client #2's training programs showed missing data for six of his programs in September 2019.</p>			W 252			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 252	<p>Continued From page 61</p> <p>1.The Handwashing program showed data was to be collected daily on the PM shift. Data was missing for the 1st, 2nd, and 16th.</p> <p>2.The Bathroom Privacy program showed data was to be collected daily on the PM shift. Data was missing for the 1st, 2nd, 4th, 9th, and 16th.</p> <p>3.The Meal Cleaning program showed data was to be collected three times a week on Tuesday, Thursday, and Saturday on the PM shift. Data was missing for the 3rd and 17th.</p> <p>4.The Money Denominations program showed data was to be collected three times a week on Monday, Wednesday, and Saturday on the PM shift. Data was missing on the 2nd.</p> <p>5.The Room Cleaning program showed data was to be collected three times a week on Tuesday, Thursday, and Saturday on the PM shift. Data was missing on the 3rd, 12, and 17th.</p> <p>6.The Communication Book program showed data was to be collected daily on the PM shift. Data was missing for the 1st, 2nd, 8th, 16th, 20th, and the 29th.</p> <p>During an interview on 10/09/19 at 3:57 PM, Staff C, Qualified Intellectual Disability Professional (QIDP), stated that there was missing data for six of Client #2's training programs.</p> <p>Client #5</p>			W 252			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 252	<p>Continued From page 62</p> <p>Record review of Client #5's QIDP Review, dated 10/07/19, showed that Client #5's training programs were missing for the month of August 2019.</p> <p>Record review of Client #5's Cutting Food program, dated September 2019, showed missing data on the 24th and the 28th.</p> <p>Record review of Client #5's Money Denomination program, dated September 2019, showed missing data on the 2nd, 5th, 8th, 10th, 12th, 23rd, and 30th.</p> <p>Record review of Client #5's Sweeping program, dated September 2019, showed missing data on the 2nd, 9th, 23rd, 24th, and 26th.</p> <p>Record review of Client #5's Replacement Behavior Training Plan, dated September 2019, showed missing data for Self-Calming Procedures on the AM shift on the 11th, 12th, 26th and 29th. It showed missing data on the PM shift for the 17th, 23rd, 24th, 27th, and the 29th.</p> <p>Record review of Client #5's Replacement Behavior Training Plan, dated September 2019, showed missing data for Problem-Solving Skills on the AM shift on the 11th, 12th, 26th, 27th, 28th, and 30th. It showed missing data on the PM shift on the 8th, 17th, 23rd, 24th, and 27th.</p> <p>During an interview on 10/10/19 at 9:10 AM, Staff A, Attendant Counselor Manager (ACM), Staff B, Psychology Associate, and Staff C, QIDP, stated there was missing data for Client 5's training programs.</p>			W 252			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 252	<p>Continued From page 63</p> <p>Client #6</p> <p>Review of the data for Client #6's training programs showed there was missing data from three programs.</p> <p>The program to stop at the crosswalk: Data was required to be collected on the weekends. No data was documented for October 5th and 6th.</p> <p>The program to lower her pants in the bathroom: Data was required to be collected daily on the AM (day) and PM (evening) shifts. No data was documented on the AM shift for October 5th, 6th, and 7th.</p> <p>The program to communicate her needs by leading staff by the hand: Data was required to be collected daily on the AM and PM shifts. No data was documented on the AM shift for October 6th and 7th.</p> <p>Review of Client #6's October 2019 15 minute-tracking sheets (documentation where she was every 15 minutes due to leaving staff supervision and placing herself in danger) showed:</p> <p>No documentation on the graveyard shift for October 1st - 7th;</p> <p>No documentation on the AM shift from 12:45 PM - 3:00 PM on October 5th, and for the day shifts on October 6th and 7th; and</p> <p>No documentation on the PM shift for the entire</p>			W 252			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
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W 252	Continued From page 64 shift on October 1st, from 8:00 PM - 11:00 PM on October 2nd , 3:00 PM - 4:45 PM on October 3rd, and 9:00 PM - 11:00 PM on October 5th.	W 252		This document was prepared by Residential Care Services for the Locator website.	
W 255	During an interview on 10/08/19 at 1:25 PM, Staff J, ACM, stated that the data described above was missing. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to make changes to programs for one of eight Sample Clients (Client's #2) and one Expanded Sample Client (Client #9). Client #2's teaching objectives were not updated or modified when he demonstrated he had learned the skills. Client #9 had a Self-Medication Plan with an objective to say the name of one medication. He was on step one of the task breakdown even though he had demonstrated that he already knew all of the steps of the task. This resulted in Clients continuing to be trained on skills they had already learned or could do before the facility developed the training programs. Findings included ... Client #2	W 255			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 255	<p>Continued From page 65</p> <p>Observation on 10/08/19 at 3:16 PM at 317/318 House, showed a Direct Care Staff (DCS) verbally cued Client #2 to wash his hands. Client #2 independently went to the sink and turned on the water. DCS verbally cued Client #2 again to wash his hands. Client #2 independently put soap on his hands, placed his hands under running water, pulled paper towels out of the dispenser on the wall, wiped his hands, and threw the used paper towels into the trash can.</p> <p>Record review of Client #2's file showed a teaching plan for Handwashing. The criteria to meet this objective was 80% of trials for two consecutive months by 12/31/19. Data collected for the month of August 2019 showed Client #2 completed this task at 100% and data analysis, completed by the state surveyor, for the month of September 2019 showed he completed this task at 96%. Client #2 remained on this program.</p> <p>Record review of Client #2's file showed a teaching plan for Bathing, "Touch the towel to his body (anywhere)." The criteria to meet this objective was 85% of trials for two consecutive months by 12/31/19. Data collected for the month of August 2019 showed Client #2 completed this task at 87% and analysis for the data, completed by the state surveyor, for the month of September 2019 showed he completed this task at 90%. Client #2 remained on this program.</p> <p>During an interview on 10/09/19 at 3:57 PM, Staff C, Qualified Intellectual Disability Professional, stated that the data had not been analyzed yet.</p>			W 255			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 255	<p>Continued From page 66</p> <p>Staff C stated that he had until the 15th of the next month to complete his analysis of the previous month's data.</p> <p>Client #9</p> <p>Observation on 10/08/19 at 8:36 AM at House 301 showed Client #9 read the name of all his medications then popped each of the medications out of the card holding the medication. Client #9 then wrote his initials on the bubble pack where he removed the medication. He then wrote his initials on the Medication Administration Record to document that he had self-administered four of his medications.</p> <p>Record review of Client #9's Self-Medication Plan, dated October 2019, showed staff would verbally prompt him to identify his medication Lamotrigine (one of the four medications he punched from the medication card). Client #9 was on the first step of the task breakdown, the last step being the ability to "punch" out the Lamotrigine with no prompting from staff.</p> <p>During an interview on 10/10/19 at 10:30 AM, Staff O, Registered Nurse, stated that he was not aware that Client #9 was able to do all of the steps in the task breakdown.</p>			W 255			This document was prepared by Residential Care Services for the Locator website.
W 257	<p>PROGRAM MONITORING & CHANGE</p> <p>CFR(s): 483.440(f)(1)(iii)</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is</p>			W 257			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019	
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W 257	<p>Continued From page 67</p> <p>failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to revise programs when the Clients did not show progression in training for two of eight Sample Clients (Clients #2 and #6). Client #2 was not progressing in his money denomination training, tying his shoes, and room cleaning programs. Client #6 did not progress in her toileting or money management training programs. This resulted in Clients continuing to be trained with programs that did not achieve results.</p> <p>Findings included ...</p> <p>Client #2</p> <p>Record review of Qualified Intellectual Disability Professional (QIDP) Review, dated 10/09/19, showed the following success rates for three of Client #2's teaching programs for 2019 as:</p> <p>1.The Money Denomination training program: February at 18%; March and April at 0%; May at 11%; June at 8%, July at 0%; and August at 20% success rates. The QIDP notes showed to continue the program.</p> <p>2.The Tying Shoes training program: February at</p>			W 257			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 257	<p>Continued From page 68</p> <p>50%, March at 40%, April at 28%, May at 6%, June at 17%, July at 3%, and August at 0% success rates. The notes for August showed to continue the program as written for September but the team agreed to amend the program if Client #2 did not make any further progress. Client #2 remains on the program.</p> <p>3.Room Cleaning training program: February at 0%; March at 50%; April at 56%, May at 0%; June at 8%; July at 25%; and August at 27%. The notes showed to continue the program.</p> <p>During an interview on 10/09/19 at 3:57 PM, Staff C, QIDP, stated that these programs were not revised.</p> <p>Client #6</p> <p>Record review of the QIDP Review, dated 10/07/19, showed a 0% success rate for the months of June 2019, July 2019, August 2019, and September 2019 for her toileting program. It also showed a 0% success rate for the months of June 2019, July 2019, and August 2019 for her money management program. The notes showed the programs continued with no changes each month.</p> <p>During an interview on 10/10/19 at 10:00 AM, Staff C, QIDP, stated that he was not sure why there were no changes on Client #6's money management program.</p>	W 257			This document was prepared by Residential Care Services for the Locator website.
W 260	PROGRAM MONITORING & CHANGE	W 260			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 260	<p>Continued From page 69 CFR(s): 483.440(f)(2)</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update an Individual Habilitation Plan (IHP) for one of eight Sample Clients (Client #1) after her heart conditioned worsened. This resulted in Client #1 not having a training plan adapted for her current health conditions, which put her life in danger.</p> <p>Findings included ...</p> <p>Review of Client #1's file showed she returned from a hospitalization on [REDACTED]/19 with a diagnosis of [REDACTED]</p> <p>[REDACTED] Symptoms may include fatigue, difficulty breathing/ breathlessness, dizziness, fluid buildup in tissue (edema), coughing, and lack of appetite), and possible pneumonia.</p> <p>Record review of Client #1's IHP Revision, dated 09/12/19, showed the Interdisciplinary Team met for Client #1's new IHP. The IHP Revision dated 09/12/19 did not provide any information related to the potential signs and symptoms staff should monitor for, and report to Licensed Nurses. It did not provide any instructions for staff related to potential modifications for Client #1's activity tolerance related to the diagnosis of [REDACTED]</p>	W 260		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 260	Continued From page 70 [REDACTED]			W 260			This document was prepared by Residential Care Services for the Locator website.
W 323	<p>During an interview on 10/10/19 at 8:10 AM, Staff P, Qualified Intellectual Disability Professional, stated that they did not change the current IHP, care, or treatment for Client #1 related to the diagnosis of [REDACTED].</p> <p>PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i)</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the annual medical examination included an evaluation of Clients' vision and hearing for four of eight Sample Clients (Clients #2, #3, #7, and #8). Client #2's examination did not include the results of a general screening about hearing. Clients #3, #7, and #8 did not include the results of a general screening about hearing and vision. This failure prevented the identification of any changes, which would need to be addressed in the Individual Habilitation Plan and referred to specialists.</p> <p>Findings included ...</p> <p>1. Record review of Client #2's Annual Health Care Assessment (AHCA), dated 04/05/19, did not contain the results of a general screening of Client #2's hearing as part of the annual health assessment.</p>			W 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 323	<p>Continued From page 71</p> <p>During an interview on 10/07/19 at 2:26 PM, Staff L, Physician, stated that the AHCA did not contain a general screening of Client #2's hearing.</p> <p>2. Record review of Client #3's Annual Healthcare Assessment, dated 08/16/19, did not contain the results of a general screening of her ability to see or hear as part of the annual health assessment.</p> <p>During an interview on 10/09/19 at 10:00 AM, Staff X, Qualified Intellectual Disability Professional (QIDP), stated that a general review of hearing and sight was not documented in the Annual Healthcare Assessment.</p> <p>3. Record review of Client #7's Annual Medical Review (AMR), dated 07/17/19, showed there was no statement of a general screening review of the status of Client #7's vision functioning and hearing functioning.</p> <p>During an interview on 10/10/19 at 9:00 AM, Staff V, QIDP, stated that Client #7's AMR, dated 07/17/19, did not have the results of a general screening review of vision functioning and hearing functioning.</p> <p>4. Record review of Client #8's AMR, dated 09/17/19, showed there was no statement of a general screening review of the status of Client #8's vision functioning and hearing functioning.</p> <p>During an interview on 10/10/19 at 9:00 AM, Staff</p>	W 323		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 323	Continued From page 72	W 323			This document was prepared by Residential Care Services for the Locator website.
W 333	<p>V, QIDP, stated that Client #8's AMR, dated 09/17/19, did not have the results of a general screening review of vision functioning and hearing functioning.</p> <p>NURSING SERVICES CFR(s): 483.460(c)(2)</p> <p>Nursing services must include the development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of eight Sample Clients (Client #1) had a comprehensive care plan for [REDACTED].</p> <p>[REDACTED] The plan did not include any interventions for the symptoms of [REDACTED] that may include fatigue, difficulty breathing/breathlessness, dizziness, fluid buildup in tissue (edema), coughing, and lack of appetite. There were no interventions listed for fall precautions to address the significant risk of injury if Client #1 fell while taking a prescription blood thinning medication. This failure prevented staff from knowing how to provide care for Client #1 in relation to her change in condition, and increased her risk of injury related to the use of an anticoagulant (blood thinning) medication because she had a history of falls with significant injury, requiring hospitalization.</p> <p>Findings included ...</p>	W 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 333	<p>Continued From page 73</p> <p>1.Care plan for heart failure Record review of Client #1's Medical Provider Progress Notes, dated [REDACTED]/19, showed she returned from a local hospital on [REDACTED]/19 with a diagnosis of [REDACTED]</p> <p>Review of Client #1's Alert Care Plans showed there were no care plans related to [REDACTED]. There were no directions for direct care staff to monitor for or report symptoms of the illnesses to licensed staff.</p> <p>During an interview on 10/10/19 at 2:21 PM. Staff O, Registered Nurse, provided an Alert Care Plan, dated 08/22/19, and stated that the care plan was discontinued after the Client was determined to be stable. When asked about the on-going illnesses, Staff O stated that information should have been included in Client #1's Individual Habilitation Plan (IHP) to address Client #1's health concerns.</p> <p>2.Care plan related to risk for significant injury from falls Record review of Client #1's Medication Administration Records, dated October 2019, showed Client #1 received Apixaban (a medication that thins the blood, used to help prevent a blood clot/stroke.) 5mg twice a day for Atrial fibrillation (an irregular heartbeat that increases a person's risk for a blood clot and stroke). Apixaban does not have a known antidote or reversal agent to control bleeding in the event surgery or significant injury occurs.</p>	W 333		This document was prepared by Residential Care Services for the Locator website.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
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OMB NO. 0938-0391

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W 333	<p>Continued From page 74</p> <p>Record review of Event Report #1005, dated 08/15/19, showed Client #1 slipped from a chair and hit her head, causing significant bleeding that resulted in a visit to the local Emergency Department.</p> <p>Record review of Client #1's Annual Healthcare Assessment, dated 08/26/19, showed:</p> <p>Client #1 had a 6% risk of stroke.</p> <p>A history of unwitnessed falls.</p> <p>Client #1 had fractures in her mid-back, identified on [REDACTED]/19 while at the hospital.</p> <p>Review of Client #1's file showed:</p> <p>An IHP Revision, dated 07/25/19, that identified, "[Client #1's first name] has experienced a number of falls over the last calendar year and it is evident that her mobility is beginning to decline."</p> <p>No documentation related to the potential for significant injury related to her history of falls while taking a prescription blood thinning medication.</p> <p>No plan of care with interventions to decrease her risk of profuse bleeding when she fell while taking the blood thinning medication, with no known treatment to decrease bleeding if she had a significant injury or if she required surgery.</p> <p>During an interview on 10/10/19 at 10:05 AM, Staff O, Registered Nurse, stated that Client #1</p>			W 333			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 333	Continued From page 75	W 333			This document was prepared by Residential Care Services for the Locator website.
W 336	<p>did not have care plans for the above medical concerns.</p> <p>NURSING SERVICES CFR(s): 483.460(c)(3)(iii)</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete quarterly nursing exams for one of eight Sample Clients (Client #1) when the Registered Nurse (RN) did not complete an exam that was due May 2019 and August 2019. This failure prevented medical staff from having current assessments of Client #1's physical condition, potentially delaying the identification of the worsening of her [REDACTED] condition, which a local hospital diagnosed in August 2019.</p> <p>Findings included ...</p> <p>Review of Client #1's file on 10/07/19 showed:</p> <p>A Nursing Quarterly Review was due for completion in May and August 2019. These two quarterly assessments were not in Client #1's file.</p> <p>During an interview on 10/10/19 at 10:05 AM, Staff O, RN, stated that nursing staff completed a quarterly review in May and a medical provider completed the Client's Annual Healthcare Assessment (AHA) in August 2019, which would negate the need for a nursing review in August</p>	W 336			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 336	Continued From page 76 2019. Staff O did not respond when the state surveyor notified him that the AHA was not in Client #1's file. Staff O was unable to provide a copy of the nursing review from May 2019.	W 336		This document was prepared by Residential Care Services for the Locator website.	
W 342	Review of Client #1's file on 10/17/19 showed the 2019 AHA was not in the file. NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide training to Direct Care Staff (DCS) for one of eight Sample Clients (Client #1) regarding [REDACTED] [REDACTED]. Symptoms of [REDACTED] may include fatigue, difficulty breathing/breathlessness, dizziness, fluid buildup in tissue (edema), coughing, and lack of appetite. The lack of staff training related to [REDACTED] symptoms placed Client #1 at an increased risk for a delay in treatment of her symptoms, pain, injury, difficulty breathing, and unnecessary hospitalization. Findings included ...	W 342			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2019
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W 342	Continued From page 77 Record review of Client #1's Medical Provider Progress Notes, dated [REDACTED]/19, showed she returned from a local hospital on [REDACTED] 19 with a diagnosis of [REDACTED]. Review of Client #1's file showed there were no care plans related to atrial fibrillation or heart failure. During an interview on 10/10/19 at 10:05 AM, Staff O, Registered Nurse, provided a copy of a staff in-service, dated 09/04/19, related to Client #1's medical condition. Record review of training records, provided during the interview above, regarding changes in the plan of care for Client #1 showed an in-service with the summary of training, "Resident returned with a POLST [Physician Order for Life Sustaining Treatment] DNR [Do Not Resuscitate]. This inservice (sic) is to clarify what that means." Seven staff members signed the in-service; all of them were staff that worked at the Activity Building, not DCS providing care for Client	W 342		This document was prepared by Residential Care Services for the Locator website.	
W 407	CLIENT LIVING ENVIRONMENT CFR(s): 483.470(a)(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assess and	W 407			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 407	<p>Continued From page 78</p> <p>document the benefit of one Expanded Sample Client (Client #9) living with Clients that did not match his developmental and social abilities. Client #9 was an active person that was very independent in caring for himself, spoke often with staff, and was independent on campus. The other Clients at the house required significant staff assistance with care; most Clients did not speak, and required staff supervision when they left the house. As a result, Client #9 was denied the opportunity to develop relationships with peers such as, but not limited to, equality, cooperation, common activities of interest, and intimacy.</p> <p>Findings included ...</p> <p>Observation at House 301 on 10/08/19 at 8:59 AM, 2:56 PM, and 3:26 PM, on 10/09/19 at 4:21 PM, 4:52 PM, 5:11 PM, and 5:14 PM showed:</p> <p>Client #9 signed himself in and out of the house and read the clock on the wall to identify the date and time.</p> <p>Client #9 answered the phone, correctly identified his location, chatted with the staff member on the phone, and provided a recap of the conversation to another staff member.</p> <p>Client #9 spoke on the phone with his dad and made plans to go swimming with his family.</p> <p>Client #9 sat at the dining room table, read his dining protocol aloud from a sheet of laminated paper, and said a "blessing" over his meal.</p> <p>Client #9 put milk containers in the refrigerator.</p>			W 407			This document was prepared by Residential Care Services for the Locator website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 407	Continued From page 79 Client #9 cut his pizza into small pieces and ate it with a fork. Observations at House 301 on 10/08/19 from 7:41 AM-9:21 AM and 1:47 PM-3:29 PM and 10/09/19 from 4:10 PM-6:15 PM showed: Of the five Clients living at House 301, one Client had a conversation with staff; the other four have extremely limited communication skills. During the above observations four of the Clients scribbled on blank pieces of paper, placed checkers in a Connect Four frame (where the checkers dropped back into the box it was sitting in, it appeared to be missing the lever to release the checkers from the frame), put wooden puzzles (4-6 piece puzzles) together, watched TV, flipped through magazines, sat unengaged, paced, or sat in chairs rocking back and forth. During an interview on 10/10/19 at 8:10 AM, Staff P, Qualified Intellectual Disability Professional, stated that Client #9 moved to House 301 when his prior house closed. Staff P stated she was not aware of any documentation as to why he went to live with the current Clients at House 301.			W 407			This document was prepared by Residential Care Services for the Locator website.
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.			W 436			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 436	Continued From page 80 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to furnish an eyeglass case and to write a training program for one of eight Sample Clients (Client #5). This failure resulted in Client #5 not learning how to care for and maintain his prescription eyeglasses. Record review of Client #5's file showed he wore prescription eyeglasses. Record review of Client #5's Individual Habilitation Program (IHP), dated 08/07/19, showed a primary need for him to manage and care for his personal belongings. Record review of Client #5's Direct Care Independent Living Skills Assessment, dated 08/07/19, showed that he could learn to store his glasses and that he needed an eyeglass case. It also showed that he needed to make sure he cleaned his eyeglasses every day and when they got dirty. Record review of Client #5's IHP, dated 08/07/19, showed no training objective around the care and maintenance of his eyeglasses. During an interview on 10/10/19 at 9:10 AM, Staff A, Attendant Counselor Manager, and Staff C, Qualified Intellectual Disability Professional, stated that they did not know if Client #5 had an eyeglass case. Staff C stated that Client #5 did not have a training objective to learn how to care for and maintain his eyeglasses.	W 436			This document was prepared by Residential Care Services for the Locator website.
W 472	MEAL SERVICES	W 472			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2019
FORM APPROVED
OMB NO. 0938-0391

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W 472	<p>Continued From page 81 CFR(s): 483.480(b)(2)(i)</p> <p>Food must be served in appropriate quantity.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide portions consistent with one of eight Sample Clients' (Client #1) diet while at the Activity Building. This failure placed Client #1 at risk for not having her nutritional needs met as prescribed.</p> <p>Findings included ...</p> <p>Observation at the Activity Building on 10/09/19 at 11:36 AM showed Staff S, Adult Training Specialist, place one scoop of ground meat, one scoop of potatoes, and one scoop of green beans on Client #1's plate.</p> <p>Record review of Client #1's lunch dining ticket, dated 10/09/19, showed her serving size as 6 meatballs, ½ cup potatoes, and ½ cup green beans.</p> <p>During an interview on 10/09/19 at 11:55 AM, Staff S stated that all Clients received 4 ounces of meat, 4 ounces of potatoes, and 6 ounces of vegetable for lunch.</p> <p>During an interview on 10/10/19 at 1:13 PM, Staff Q, Food Service Supervisor, stated that staff could not substitute a scoop of ground meat as the equivalent of six meatballs. Staff Q stated that serving ladles had specific sizes for different diets and staff should use specific serving ladles</p>			W 472			This document was prepared by Residential Care Services for the Locator website.

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W 472	Continued From page 82 for specific diets, not the same size of scoop for all Clients.			W 472			This document was prepared by Residential Care Services for the Locator website.
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide the correct diet texture to one of eight Sample Clients (Client #2). Client #2 received two snacks that were not pureed as prescribed in his diet orders. This endangered Client #2's health and safety; such as choking or aspiration (when food or saliva enters the airway and lungs). Findings included... Record review of Client #2's Diet Orders, dated 07/17/19, showed Client #2 was prescribed a pureed diet for all meals. Observation on 10/08/19 at 9:55 AM at Adult Training Building showed Client #2 received a snack of cottage cheese that was not pureed. Observation on 10/08/19 at 2:48 PM at 317 House showed Client #2 received a snack of a dry, crumbled, and mashed down muffin on a plate.			W 474			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 474	Continued From page 83 During an interview on 10/08/19 at 3:06 PM, Staff C, Qualified Intellectual Disability Professional, and Staff T, Speech Language Pathologist, stated that Client #2's diet texture was pureed.	W 474		This document was prepared by Residential Care Services for the Locator website.	



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
FIRCREST RHC
B17-31 • 15230 – 15th Ave NE • Shoreline WA 98155-7196

December 11, 2019

Gerald Heilinger, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, Mail Stop: 45600
PO Box 45600
Olympia, WA 98504-5600
RE: GEY311

Dear Mr. Heilinger:

From 10/07/2019 through 10/11/2019 ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (AL TSA) conducted recertification survey at Fircrest RHC.

We submitted a revised Plan of Correction for the deficiencies identified on the CMS 2567 Statement of Deficiencies we received on October 30, 2019 on December 2, 2019, which was accepted on December 9, 2019.

We are now submitting a second revised Plan of Correction with some changes to dates.

If you have any questions, please do not hesitate to contact me at 206-361-3032.

Thank you.

Sincerely,

Upkar Mangat
Superintendent-Fircrest RHC

This document was prepared by Residential Care Services for the Locator website.

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W104 Governing Body

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility's Governing Body failed to provide oversight of the kitchen to ensure Clients at the Activity Building received the correct meal for lunch on 10/09/19. This failure resulted in all Clients receiving ground meat, instead of meatballs.

Facility Analysis of the Processes that led to the Deficiency:

- The kitchen sent the wrong food option and texture to the Activities Building because the cook forgot to send the tray with meatballs. The ground meat met the need of some clients at the Activities Building at that time but not all. The Dietary Supervisor already addressed the error with the cook. A staff member identified it was not the correct meal option, the kitchen was not called to correct the issue because the Adult Training Specialist staff did not know they should inform them of the mistake. This was immediately addressed with the Adult Training Specialist by the Adult Programs Director. This was not a meal substitute sent by the kitchen; it was human error.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 29, 2019.

Immediate Actions:

- The kitchen was notified that what was sent was not the meal identified in the menu. The kitchen was asked to ensure that food will be sent as written on the menu.

STEPS FOR POC:

- The Speech-Language Pathologists will in-service all Adult Training Specialists while at the Activities Building on following dining guidelines to ensure that all clients are receiving the diet texture that they have been assessed for.
 - Person Responsible: Speech-Language Pathologists with oversight by the Therapies Supervisor
 - Completion Date: November 15, 2019
- The kitchen will be in-serviced by the Food Service Manager on following the menus as they are dictated on the schedule. If there are last minute changes, the meal tickets will be adjusted and notifications will be made to the impacted area. The in-service will also include diet textures so that all residents receive the diet texture that they were assessed for.
 - Person Responsible: Food Service Manager
 - Completion Date: November 15, 2019
- An e-mail will be sent to all staff by the Program Area Director regarding who to contact if the food from the kitchen is not correct to ensure that all clients receive the diet texture they are assessed for.
 - Person Responsible: Program Area Director
 - Completion Date: November 15, 2019

Superintendent

Signature Title

12/11/19

Date

4. The Speech-Language Pathologists will complete one meal observation each at the Activities Building to ensure that the correct textures are being sent to the Activities Building.
 - Person Responsible: Speech-Language Pathologists with oversight by the Therapies Director
 - Completion Date: December 10, 2019
5. The Occupational Therapists will complete one meal observation each at the Activities Building to ensure that the correct diet textures are being sent to the Activities Building.
 - Person Responsible: Occupational Therapists with oversight by the Therapies Director
 - Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. The Quality Assurance department will complete one meal observation per month at the Activities Building to ensure that the clients are receiving the diet textures that they were assessed for per their dining guidelines and that meal tickets represent the menu items for that meal.
 - Person Responsible: Quality Assurance Department
2. The Adult Programs Director will complete one meal observation per month at the Activities Building to ensure that the clients are receiving the diet textures that they were assessed for per their dining guidelines and that meal tickets represent the menu items for that meal.
 - Person Responsible: Adult Programs Director

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Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W104 Governing Body

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility's Governing Body failed to provide oversight to ensure the Qualified Intellectual Disability Professional (QIDP) implemented one of eight Sample Clients' (Client #1) Individual Habilitation Plan (IHP) within the facility's policy time line. Client #1's IHP, dated 09/12/19, was not finalized or filed in her record. This failure resulted in Client #1 not having a current IHP available to staff.

Facility Analysis of the Processes that led to the Deficiency:

- A change in condition Individual Habilitation Plan meeting was held on September 12, 2019 for Client #1. During this time, the facility had lost 3 Habilitation Plan Administrators for various reasons. The Habilitation Plan Administrator for Client #1 was transitioning to another unit and continuing to provide coverage on Client #1's unit while a replacement was being hired and trained. The Habilitation Plan Administrator had several investigations, team responsibilities, and meetings to complete for two units. The workload was too much and the Habilitation Plan Administrator was only two days late in turning in the change in condition Individual Habilitation Plan for Client #1. The Developmental Disabilities Administrator that was assigned for review was also out on authorized medical leave. The Developmental Disabilities Administrator's counterpart did not receive the program for review to support the process. Upon return from leave, the Developmental Disabilities Administrator had competing priorities for the few days leading into survey. Survey arrived and the Developmental Disabilities Administrator then shifted her focus to her caseload to support them through the survey process. Both the Habilitation Plan Administrator and Developmental Disabilities Administrator are aware of the expected process for timeliness and their mistake.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 30, 2019.

Immediate Actions:

- Client #1's change in condition Individual Habilitation Plan dated September 12, 2019 was reviewed.
- Client #1 was transitioned to a Nursing Facility.

STEPS FOR POC:

- The Habilitation Plan Administrator responsible for Client #1's Individual Habilitation Plan will be in-serviced by the Developmental Disabilities Administrator on the expectations of Individual Habilitation Plan timelines.
 - Person Responsible: Developmental Disabilities Administrator with oversight by the Program Area Director
 - Completion Date: December 2, 2019

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Date

2. All Habilitation Plan Administrators will be in-serviced by the Developmental Disabilities Administrators on the importance of following Individual Habilitation Plan timelines to ensure timely implementation of the program after due process has been obtained. The timelines will include a significant change Individual Habilitation Plan having the same timeline and process to ensure that all significant changes are made to keep the clients healthy and safe.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: November 26, 2019
3. All Habilitation Plan Administrators will be in-serviced by the Developmental Disabilities Administrators regarding Individual Habilitation Plan revisions for changes in condition while review and due process is completed on the new Individual Habilitation Plan.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: November 26, 2019
4. The Developmental Disabilities Administration policy will be updated to reflect the current practice and expectations.
 - Person Responsible: Program Area Director
 - Completion Date: December 6, 2019
5. All professional staff will be in-serviced on the updated Developmental Disabilities Administration policy.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
6. A system is now in place for the Developmental Disabilities Administrators to cover each other's caseloads when on leave.
 - Person Responsible: Program Area Director
 - Completion Date: October 28, 2019

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrators will track the timeliness of all Individual Habilitation Plans and counsel all Habilitation Plan Administrators when they do not meet the established expected timelines.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W104 Governing Body

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility's Governing Body failed to provide oversight of their policy to address end-of-life decisions for one of eight Sample Clients' (Client #1) significant change in her physical condition. This failure resulted in Client #1's plan of care not being updated, the Client/Guardian were not educated on the Client's right to receive palliative care/hospice care, and end-of-life decisions.

Facility Analysis of the Processes that led to the Deficiency:

- The medical staff did not contact the guardian regarding palliative care, hospice care, and end-of-life decisions because the guardians had only agreed to it one day prior to returning to the facility from the hospital. The Physician states that had the timeframe not been so close, one day, the guardian would have been contacted directly by the Physician. The guardians were educated by the hospital. The facility policy states that if a Client arrives at the facility with a completed POLST it will be implemented.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 29, 2019.

Immediate Actions:

- Client #1 transitioned to a Nursing Facility.

STEPS FOR POC:

- The Health Records Technician will send an e-mail to all Habilitation Plan Administrators to get a list of individuals that have Physician Order for Life Sustaining Treatments in the charts.
 - Person Responsible: Health Records Technician with oversight by Quality Assurance Director
 - Completion Date: October 29, 2019
- For all clients that are identified as having a Physician Order for Life Sustaining Treatments, an Individual Habilitation Plan Revision will be completed.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 6, 2019
- All Direct Care staff working with a client that has a Physician Order for Life Sustaining Treatments will be in-serviced regarding how to implement the Physician Order for Life Sustaining Treatments.
 - Person Responsible: Healthcare Coordinator with oversight by the Program Area Director
 - Completion Date: December 6, 2019
- For the clients with a Physician Order for Life Sustaining Treatments in place, a discussion regarding the other possible options, such as, but not limited to, palliative and hospice care will take place. This will ensure that the client and guardian are aware of all options and can make an informed decision regarding end-of-life supports.

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Date

- Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
5. All Habilitation Plan Administrators will be in-serviced on the Developmental Disabilities Administration policy supporting end-of-Life Decisions in Residential Habilitation Centers. The in-service will include that when a Physician Order for Life Sustaining Treatments is put into place, all Direct Care Staff must be trained on how to implement the Physician Order for Life Sustaining Treatments.
- Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: December 6, 2019

Monitoring Procedure for Implementing the POC:

1. Annually, at the Individual Habilitation Plan meeting, the Habilitation Plan Administrators will ensure discussion of the Physician Orders for Life Sustaining Treatments and document in the Individual Habilitation Plan.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
2. The Developmental Disabilities Administrators will review, through the current process, each Individual Habilitation Plan prior to implementation and determine if there was a discussion about the Physician's Order for Life Sustaining Treatments.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W104 Governing Body

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility's Governing Body failed to ensure they had a process for all staff to follow that identified how the facility would manage their Client record system, including, but not limited to: what to file in the Client record, how the maintenance of the record occurred, and who would maintain it. Some assessments were located in a physical file and some were on the facility online SharePoint. This failure resulted in one of eight Sample Clients' (Client #1) having an incomplete record.

Facility Analysis of the Processes that led to the Deficiency:

- The facility did not have a standard operating procedure which outlined what a client record included, maintenance of the record, and who would maintain it.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 14, 2019.

Immediate Actions:

- Began drafting a Client Records Standard Operating Procedure for the facility and updating the Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure.

STEPS FOR POC:

- A Client Records Standard Operating Procedure will be developed. The Client Records Standard Operating Procedure will include what to file in the Client record, how the maintenance of the record occurred, and who will maintain it.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
- Once the Client Records Standard Operating Procedure has been developed and approved, all staff will be in-serviced to ensure that everyone is aware of their responsibility related to the Client record.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
- The Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure will be updated to include who is responsible for filing.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
- All professional staff will be in-serviced on the updated Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure, which includes who is responsible for filing.
 - Person Responsible: Program Area Director

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Date

- Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. Annually, the Quality Assurance Department will review the Client Records and Interdisciplinary Team Roles and Responsibilities Standard Operating Procedures to ensure they include the most current information.
 - Person Responsible: Quality Assurance Department
2. Quarterly, the Developmental Disabilities Administrators will do one chart review for each Habilitation Plan Administrator on their caseload to ensure that the client file includes all necessary information.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
3. Quarterly, the Quality Assurance Department will do a random sample of chart reviews to ensure that the client file includes all necessary information.
 - Person Responsible: Quality Assurance Department

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Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W104 Governing Body

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility's Governing Body failed to ensure staff entered all Client assessments into their physical record after completion of the assessments, This failure resulted in staff, Clients, and guardians not having current information available in the Client's record.

Facility Analysis of the Processes that led to the Deficiency:

- The facility did not have a standard operating procedure which outlined what a client record included, when assessments would be filed in the client record, maintenance of the record, and who would maintain it.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 14, 2019.

Immediate Actions:

- Began drafting a Client Records Standard Operating Procedure for the facility and updating the Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure.

STEPS FOR POC:

- A Client Records Standard Operating Procedure will be developed. The Client Records Standard Operating Procedure will include what to file in the Client record, how the maintenance of the record occurred, and who will maintain it.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
- Once the Client Records Standard Operating Procedure has been developed and approved, all staff will be in-serviced to ensure that everyone is aware of their responsibility related to the Client record.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
- The Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure will be updated to include who is responsible for filing.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
- All professional staff will be in-serviced on the updated Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure, which includes who is responsible for filing.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019

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Monitoring Procedure for Implementing the POC:

1. Annually, the Quality Assurance Department will review the Client Records and Interdisciplinary Team Roles and Responsibilities Standard Operating Procedures to ensure they include the most current information.
 - Person Responsible: Quality Assurance Department
2. Quarterly, the Developmental Disabilities Administrators will do one chart review for each Habilitation Plan Administrator on their caseload to ensure that the client file includes all necessary information.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
3. Quarterly, the Quality Assurance Department will do a random sample of chart reviews to ensure that the client file includes all necessary information.
 - Person Responsible: Quality Assurance Department

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Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W104 Governing Body

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility's Governing Body failed to Develop a process to ensure staff obtained routine Client weights, or weights as ordered by a Physician. There was no process to ensure weights were obtained under consistent conditions, such as but not limited to, what time of day to obtain the weight, what clothing the Client should wear, how to resolve a difference in weight, how to analyze and report weight changes, or what action to take if staff did not obtain a weight. This failure prevented the facility from identifying changes in Client's weights, prevented staff from implementing interventions related to weight changes, and identifying if an appropriate plan was in place for Clients requiring weight monitoring.

Facility Analysis of the Processes that led to the Deficiency:

- The facility did not have a standard operating procedure in place to identify when staff should obtain routine client weights, weights ordered by a Physician, what conditions the weight should be completed, how to resolve a difference in weight, how to analyze and report weight changes, or what action to take if a staff did not obtain a weight.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 23, 2019.

Immediate Actions:

- Began draft for Weight Policy.

STEPS FOR POC:

- A Height and Weight Policy is being developed by the Registered Nurse-4 to provide a procedure on how to obtain Client height and weight. This policy will include instruction to obtain height and weight under consistent conditions, such as but not limited to, what time of day to obtain the height and weight, what clothing the Client should wear, how to analyze and report height or weight changes, or what action to take if staff did not obtain height or weight.
 - Person Responsible: Registered Nurse-4
 - Completion Date: December 6, 2019
- All Healthcare Coordinators will be in-serviced on the updated Height and Weight Policy, which will include directives regarding steps to take when a weight check is missed.
 - Person Responsible: Registered Nurse-4 with oversight by the Program Area Director
 - Completion Date: December 10, 2019
- Once the Height and Weight policy has been approved, all Direct Care Staff will be in-serviced on the policy prior to implementation.
 - Person Responsible: Healthcare Coordinator with oversight by the Program Area Director

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- Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. Healthcare Coordinators will check weight at least quarterly as part of the quarterly nursing assessment. If discrepancies are noted, the physician will be notified.
 - Person Responsible: Healthcare Coordinators with oversight by the Registered Nurse-4
2. Habitation Plan Administrators will monitor weights for the Qualified Intellectual Disabilities Professional Review notes.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director

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Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W110 Client Records

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to develop a written process to manage Client records for one of eight Sample Clients (Client #1), which included, but not limited to what documents would be filed in the Client record, how the Client record would be kept current, and who would keep the record current. Some Client assessments and other documents were located on the facility SharePoint online, not in the physical record. This failure resulted in Client information being located in various places, potentially causing delay in treatment, and decisions based on partial information that would affect Client health, safety, and training.

Facility Analysis of the Processes that led to the Deficiency:

- The facility did not have a standard operating procedure which outlined what a client record included, maintenance of the record, and who would maintain it.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 24, 2019.

Immediate Actions:

- Began drafting a Client Records Standard Operating Procedure for the facility and updating the Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure.

STEPS FOR POC:

- A Client Records Standard Operating Procedure will be developed. The Client Records Standard Operating Procedure will include what to file in the Client record, how the maintenance of the record will occur, and who will maintain it.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
- Once the Client Records Standard Operating Procedure has been developed and approved, all staff will be in-serviced to ensure that everyone is aware of their responsibility related to the Client record.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
- The Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure will be updated to include who is responsible for filing.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
- All professional staff will be in-serviced on the updated Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure, which includes who is responsible for filing.

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- Person Responsible: Program Area Director
- Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. Annually, the Quality Assurance Department will review the Client Records and Interdisciplinary Team Roles and Responsibilities Standard Operating Procedures to ensure they include the most current information.
 - Person Responsible: Quality Assurance Department
2. Quarterly, the Developmental Disabilities Administrators will do one chart review for each Habilitation Plan Administrator on their caseload to ensure that the client file includes all necessary information.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
3. Quarterly, the Quality Assurance Department will do a random sample of chart reviews to ensure that the client file includes all necessary information.
 - Person Responsible: Quality Assurance Department

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Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W111 Client Records

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to ensure one of eight Sample Clients (Client #1) had a complete record that reflected her current medical condition and her functional abilities. Her Annual Healthcare Assessment (AHA) was not in her record 42 days after completion of the assessment. Additional assessments and a new Individual Habilitation Plan (IHP) were completed and the documents were stored on the facility online SharePoint, not in the physical record. This failure prevented staff from having current information available and prevented the Client/Guardian access to the information.

Facility Analysis of the Processes that led to the Deficiency:

- Client #1's Annual Healthcare assessment was completed but had not been placed into the physical chart 42 days after the assessment was completed. The Annual Healthcare Assessment was on SharePoint; however, with direct care staff being unable to easily access the file they could not review the most updated health information related to Client #1. In addition, the facility did not have a standard operating procedure which outlined who was responsible to file in the client chart which led to the Annual Healthcare Assessment not being filed.
- In this particular case, the Administrative Assistant for the medical staff was the person responsible to place completed Annual Healthcare Assessments in the mailboxes for the Healthcare Coordinators to place in the client file. She stated that she made a mistake. It was printed and ready for the appropriate mailbox, however it got covered by other papers on the desk and it was forgotten.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 24, 2019.

Immediate Actions:

- Client #1's Annual Healthcare assessment was placed into her physical chart so that the most current health information was accessible.
- Began drafting a Client Records Standard Operating Procedure for the facility and updating the Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure.
- All Client files were reviewed for the Annual Healthcare assessment.

STEPS FOR POC:

- A Client Records Standard Operating Procedure will be developed. The Client Records Standard Operating Procedure will include what to file in the Client record, how the maintenance of the record occurred, and who will maintain it.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019

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2. Once the Client Records Standard Operating Procedure has been developed and approved, all staff will be in-serviced to ensure that everyone is aware of their responsibility related to the Client record.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
3. The Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure will be updated to include who is responsible for filing.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
4. All professional staff will be in-serviced on the updated Interdisciplinary Team Roles and Responsibilities Standard Operating Procedure, which includes who is responsible for filing.
 - Person Responsible: Program Area Director
 - Completion Date: December 10, 2019
5. There is a defined timeline for the Annual Medical Review Process which clearly outlines who is responsible for each step in the process. The Health Care Coordinators will be in-serviced on the expectation of tracking the Annual Medical Reviews to make sure they are filed in a timely manner.
 - Person Responsible: Registered Nurse 4 with oversight by the Program Area Director
 - Completion Date: December 10, 2019
6. There is a defined timeline for the Annual Medical Review Process which clearly outlines who is responsible for each step in the process. The Physicians will be in-serviced on the expectation of completing the Annual Medical Review to ensure they are timely.
 - Person Responsible: Superintendent
 - Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. Annually, the Quality Assurance Department will review the Client Records and Interdisciplinary Team Roles and Responsibilities Standard Operating Procedures to ensure they include the most current information.
 - Person Responsible: Quality Assurance Department
2. Quarterly, the Developmental Disabilities Administrators will do one chart review for each Habilitation Plan Administrator on their caseload to ensure that the client file includes all necessary information.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
3. Quarterly, the Quality Assurance Department will do a random sample of chart reviews to ensure that the client file includes all necessary information.
 - Person Responsible: Quality Assurance Department

Signature / Title

Date

Plan of Correction

DATE OF SOD 10/11/2019
DATE OF POC 10/28/2019

CITATION

Citation: W124 Protection of Client Rights

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to discuss and document the risk and benefit of medical treatment for one of eight Sample Clients (Client #1). The facility did not provide the Client and her guardian with information to make an informed decision regarding the risk and benefit of various treatment options. This resulted in the facility making treatment decisions rather than ensuring the Client and her guardian had detailed information and alternative choices to determine if the risk of falling and being significantly injured was greater than the potential of having a stroke, or if other medications/treatments were a better alternative.

Facility Analysis of the Processes that led to the Deficiency:

- Client #1 was diagnosed with [REDACTED]. Following the diagnosis of [REDACTED] the Medical Provider prescribed a blood thinning medication to lower possible complications of the [REDACTED] such as a stroke. The Medical Provider diagnosed Client #1 with [REDACTED] and started rate control medications after consultation with the Cardiologist. Documentation of guardian notification was inconsistent although it is normal practice to call the guardians when beginning new medications.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is November 7, 2019.

Immediate Actions:

- The guardian was called to discuss the medication and the risk and benefit of using and not using as well as alternative treatment options.

STEPS FOR POC:

- The Superintendent will in-service the physicians on the process required before starting a new medication. This in-service will include that prior to starting a new medication, the physician or designee will notify the guardian of the addition and discuss the risks and benefits of using and not using the medication as well as alternative treatment options. The physician or designee will document this conversation in the client file and notify the Habilitation Plan Administrator.
 - Person Responsible: Superintendent
 - Completion Date: December 10, 2019
- Healthcare Coordinators, who may act as the physician designee, will be in-serviced regarding the process required before starting a medication. This in-service will include that prior to starting a new medication, the physician or designee will notify the guardian of the addition and discuss the risks and benefits of using and not using the medication as well as alternative treatment options. The physician

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or designee will document this conversation in the client file and notify the Habilitation Plan Administrator.

- Person Responsible: Registered Nurse-4 with oversight of Program Area Team Director
- Completion Date: December 10, 2019

3. All Habilitation Plan Administrators will be in-serviced to document the guardian notification and implementation of new medication(s) in the Qualified Intellectual Disabilities Professional review.

- Person Responsible: Habilitation Plan Administrators with oversight of Program Area Team Director
- Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. The Physician and/or designee will ensure that guardian notification of new medications is completed and documented.
 - Person Responsible: Medical Director
2. During the quarterly medication review, the Habilitation Plan Administrators will verify that guardian notification for new medications was completed and documented.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director

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Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W125 Protection of Client Rights

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to protect one of eight Sample Clients' (Client #5) rights. The facility made Client #5 use adaptive equipment while eating despite the facility Human Rights Committee's (HRC) disagreement with the rationale for use, and lack of approval for the equipment. This failure resulted in Clients being vulnerable to the facility doing what the facility wanted rather than ensuring the protection of Clients, making the HRC irrelevant, when the intention of the Human Rights Committee was to protect Client rights.

Facility Analysis of the Processes that led to the Deficiency:

- There is a system in place to obtain due process prior to implementation of a restrictive procedure. In this case there was an approved 30 day consent with due process and when the full program went through the Human Rights Committee it was disapproved based on the justification that the restriction would prevent spillage. The Committee disagreed that this was justification enough to continue implementation of the restriction. Client #5's Habilitation Plan Administrator was scheduled for their last day of employment and while trying to finish certain tasks, did not attend in detail to this task and remove the disapproved restriction from the clients program. This was not a case of implementing a restriction without due process; it was not removing it after re-consideration from the Human Rights Committee.
- The Developmental Disabilities Administrator that was responsible for the Habilitation Plan Administrator's reviews did not follow up on the program due to not being able to keep up with the attention to detail needed in that position. The Habilitation Plan Administrator's last day at the facility was September 3, 2019 and the Developmental Disabilities Administrator transferred to a position more suited to the employee's skill set.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 14, 2019.

Immediate Actions:

- The adaptive equipment has been removed from the Individual Habilitation Plan.

STEPS FOR POC:

- The Quality Assurance Department will send out the Human Rights Committee approvals and disapprovals to the entire Interdisciplinary Team following the meeting so all disciplines are aware of consent being disapproved and/or requiring follow up.
 - Person Responsible: Quality Assurance Director
 - Completion Date: October 14, 2019

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2. When restrictions are disapproved by Human Rights Committee and/or require follow up the Quality Assurance Department will follow up with an e-mail requesting further information and/or an updated consent.
 - Person Responsible: Management Analyst-3 with oversight by the Quality Assurance Director
 - Completion Date: October 14, 2019
3. The Habilitation Plan Administrators will update the monthly metrics to ensure all restrictions are identified and corresponding due process has been obtained. This will be updated monthly and track added restrictions and due process.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 2, 2019
4. All professional staff will supply a list of their assessed needed restrictive devices for their caseload to the Quality Assurance Director and Developmental Disabilities Administrator to include the restrictive device and date of due process per restrictive device. The list will then be provided to the appropriate Habilitation Plan Administrator. The Habilitation Plan Administrator will use this list to compare to the identified Client's Individual Habilitation Plan, obtained consent and due process, and the monthly metrics. If inconsistencies are identified either by the professional not being able to verify due process or the Habilitation Plan Administrator not having the same information in the Individual Habilitation Plan, immediate actions will be taken to correct the program or obtain due process.
 - Person Responsible: Quality Assurance Director
 - Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. The Quality Assurance Department will complete a chart review for consents that were disapproved by the Human Rights Committee to ensure the correct follow up was completed such as but not limited to the restriction being removed from the program.
 - Person Responsible: Quality Assurance Department
2. The Developmental Disabilities Administrator will review the monthly metrics to ensure all restrictions are identified and have due process. They will also review the monthly metrics during program reviews to ensure accuracy of the monthly metrics.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Signature / Title

Date

Plan of Correction

DATE OF SOD 10/11/2019
DATE OF POC 10/28/2019

CITATION

Citation: W157 Protection of Client Rights

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to complete corrective action to address an identified deficiency from an investigation for one expanded Sample Client (Client #10). Staff placed Client #10 in an emergency hold without authorization from a Qualified Intellectual Disability Professional (QIDP), as facility policy instructed. The facility's investigation failed to identify the need for staff training for emergency restraint procedures. Client #10's rights were violated, and without training all staff on emergency restraint procedures, all Clients were vulnerable to being restrained without proper authorization.

Facility Analysis of the Processes that led to the Deficiency:

- On September 9, 2019 the staff did call for a support team which did follow policy. The Qualified Intellectual Disabilities Professional had a radio to hear the call and respond. The Qualified Intellectual Disabilities Professional was in their office located in the basement of a building that did not have good reception. The Residential Service Coordinators located in the Duty Office had previously been asked to call the Qualified Intellectual Disabilities Professional by telephone for response if they did not hear them on the radio or did not see them at the location of support needed. The Duty Office did not call. The policy did not clearly separate out directions for staff regarding emergency restraints and plan approved restraints because the staff action is the same: call a support team. It is also the same response for a Qualified Intellectual Disabilities Professional: when you hear the support team call, a Qualified Intellectual Disabilities Professional responds.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 31, 2019.

Immediate Actions:

- Began the facility began the process of updating the Fircrest Restraint Standard Operating Procedure I.A.06

STEPS FOR POC:

- The Fircrest Restraint Standard Operating Procedure I.A.06 was updated to reflect the responsibility of the Qualified Intellectual Disability Professional regarding authorization of an emergency restraint.
 - Person Responsible: Quality Assurance Director
 - Completion Date: October 31, 2019
- All Qualified Intellectual Disability Professionals will be in-serviced on the updated Fircrest Restraint Standard Operating Procedure I.A.06 to ensure understanding that they know they always have to authorize emergency restraints, whether it is during the restraint or after the restraint. The Qualified Intellectual Disability Professional will also provide a written statement regarding the restraint.

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- Person Responsible: Lead Psychologist
- Completion Date: December 10, 2019
- 3. There will be a quarterly Qualified Intellectual Disabilities Professional meeting to discuss any changes in programs for the clients.
 - Person Responsible: Lead Psychologist
 - Completion Date: December 10, 2019
- 4. The Residential Services Coordinators will be in-serviced on the updated Fircrest Restraint Standard Operating Procedure I.A.06 to ensure understanding of expectation that a Qualified Intellectual Disabilities Professional must be called during or after an emergency restraint for authorization. This in-service will also include calling by telephone when the Qualified Intellectual Disabilities Professional does not respond via radio they have received the call.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
- 5. All staff will be in-serviced on the updated Fircrest Standard Operating Procedure I.A.06. The in-service will include that a Qualified Intellectual Disabilities Professional must be called during or after an emergency restraint for authorization.
 - Person Responsible: Psychologists with oversight by the Lead Psychologist
 - Completion Date: December 10, 2019
- 6. A new radio system was implemented which included greater coverage for radio communication and less opportunity for the Qualified Intellectual Disabilities Professional to not receive the call for a support team.
 - Person Responsible: Assistant Superintendent
 - Completion Date: October 21, 2019

Monitoring Procedure for Implementing the POC:

1. During incident management meetings, Restraint Event Reports will be reviewed to ensure that there is a signature from a Qualified Intellectual Disabilities Professional and an additional statement from the Qualified Intellectual Disabilities Professional for emergency restraints. If there is not, the Developmental Disabilities Administrators will follow up with the assigned Qualified Intellectual Disabilities Professional.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. The Quality Assurance Department will review all investigations and corresponding plans of corrections to ensure they are reasonably likely to prevent the potential violation of client rights in the future.
 - Person Responsible: Quality Assurance Director

Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W159 QIDP-Client #1

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure their Qualified Intellectual Disability Professional (QIDP) oversaw every part of three of eight Sample Clients' (Clients #1, #2, and #5) active treatment training plans. The QIDP did not update Client #1's bathing program to reflect her current training plans. The QIDP did not ensure Client #2's teaching plans provided clear instructions for staff to implement; his active treatment schedule did not reflect his most current individual Habilitation plan (IHP); Direct Care Staff (DCS) did not implement teaching plans as written, did not record data as required for analysis; and the Client's programs were not updated when objectives were achieved. The QIDP did not change Client #2's programs where refusals occurred or when no progression occurred for several months of teaching the same objective. The QIDP did not train Client #5's DCS when a program's time was changed from AM to PM, his teaching plans had conflicting prompts for DCS, DCS did not provide data to analyze programs, his training instructions were not changed when his work schedule changed, and his rights were restricted with the authorization from the Human Rights Committee (HRC). The lack of oversight by the QIDPs perpetuated the dysfunction within the facility's Active Treatment loop.

Facility Analysis of the Processes that led to the Deficiency:

- Client #1's Interdisciplinary Team had agreed that Client #1 met the criteria for their current objective and, therefore, should be moved on according to the analysis in the Qualified Intellectual Disabilities Professional Review. This agreed upon modification was not updated on Client #1's bathing teaching plan, therefore, Client #1 was working on a skill that had already been learned.
- The Habilitation Plan Administrator for Client #1 was transitioning to another unit and continuing to provide coverage on Client #1's unit while a replacement was being hired and trained. The Habilitation Plan Administrator had several investigations, team responsibilities, and meetings to complete for two units. The workload was too much and the Habilitation Plan Administrator was only two days late in turning in the change in condition Individual Habilitation Plan for Client #1. This was human error.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 14, 2019.

Immediate Actions:

- Client #1 has moved out of the Intermediate Care Facility due to medical needs.

STEPS FOR POC:

- All Habilitation Plan Administrators will be in-serviced that, if the Interdisciplinary Team has determined that a Client has met the criteria for an objective and should be moved on, then it has to be reflected in both the Qualified Intellectual Disabilities Professional Review and the teaching programs. Emphasis

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will be placed on the need to do program modifications to ensure that active treatment is implemented as written.

- Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
2. All Habilitation Plan Administrators will be in-serviced to incorporate reviewing teaching plans and client progress at the mini-team meetings.
- Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. The Developmental Disabilities Administrators will attend one mini-team meeting a month for a Habilitation Plan Administrator that they supervise to ensure client progress in teaching plans is on the agenda and being discussed as well as providing support for any follow up that is identified.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W159 QIDP-Client #2

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure their Qualified Intellectual Disability Professional (QIDP) oversaw every part of three of eight Sample Clients' (Clients #1, #2, and #5) active treatment training plans. The QIDP did not update Client #1's bathing program to reflect her current training plans. The QIDP did not ensure Client #2's teaching plans provided clear instructions for staff to implement; his active treatment schedule did not reflect his most current individual Habilitation plan (IHP); Direct Care Staff (DCS) did not implement teaching plans as written, did not record data as required for analysis; and the Client's programs were not updated when objectives were achieved. The QIDP did not change Client #2's programs where refusals occurred or when no progression occurred for several months of teaching the same objective. The QIDP did not train Client #5's DCS when a program's time was changed from AM to PM, his teaching plans had conflicting prompts for DCS, DCS did not provide data to analyze programs, his training instructions were not changed when his work schedule changed, and his rights were restricted with the authorization from the Human Rights Committee (HRC). The lack of oversight by the QIDPs perpetuated the dysfunction within the facility's Active Treatment loop.

Facility Analysis of the Processes that led to the Deficiency:

- The Habilitation Plan Administrator did not write instructions that were clear for staff to successfully follow and implement consistently. This particular Habilitation Plan Administrator no longer works at the facility and the new Habilitation Plan Administrator for that caseload did not effectively review the program and make changes. Client #2's boot scraping teaching program was not run as written with acknowledgement of the Adult Training Specialist-2 that they were aware that they did not run the program as written which is a performance issue and will be addressed by the Supervisor. The Adult Training Specialist-2 did not notify the Adult Training Specialist-3 that the location identified in the teaching program was no longer part of Client #2's daily schedule.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is November 7, 2019.

Immediate Actions:

- Client #2's Active Treatment Schedule was updated to reflect current programs, supervision level, and prioritized needs.
- Client #2's data collection will be checked daily to ensure that there is no missing data.
- Client #2's teaching programs were reviewed and modifications were made to ensure that Client #2 receives all teaching opportunities.

STEPS FOR POC:

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1. Client #2's Active Treatment Schedule was updated to reflect current programs, supervision level, and prioritized needs.
 - Person Responsible: Habilitation Plan Administrator
 - Completion Date: November 7, 2019
2. All Clients that reside on the same unit as Client #2 will have their Active Treatment Schedules reviewed to ensure that the programming, supervision levels, and prioritized needs are accurate. If they are not, the Active Treatment Schedule will be updated and replaced in the Client's program books.
 - Person Responsible: Habilitation Plan Administrator
 - Completion Date: December 10, 2019
3. The Direct Care Staff on Client #2's unit will be in-serviced to run teaching programs as written to ensure consistency.
 - Person Responsible: Habilitation Plan Administrator
 - Completion Date: December 10, 2019
4. The Adult Training Specialists will be in-serviced to notify the program authors' when there are noted changes needed in teaching programs.
 - Person Responsible: Adult Program Supervisors with oversight by the Adult Program Director
 - Completion Date: December 10, 2019
5. The Adult Training Specialists will be in-serviced to run programs as written to ensure consistency.
 - Person Responsible: Adult Program Supervisors with oversight by the Adult Program Director
 - Completion Date: December 10, 2019
6. The Direct Care Staff on Client #2's unit will be in-serviced on the importance of taking data consistently in order to provide the most appropriate training opportunities for the clients.
 - Person Responsible: Attendant Counselor Manager
 - Completion Date: December 10, 2019
7. All Direct Care Staff will be in-serviced on the importance of taking data consistently in order to provide the most appropriate training opportunities for the clients.
 - Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director
 - Completion Date: December 10, 2019
8. The Habilitation Plan Administrator for Client #2 will be in-serviced on analyzing data and monitoring of programs to ensure that programs are modified to provide the most appropriate training opportunities. This in-service will include modifying programs when there is a lack of progress and ways to make adjustments to see if the Clients can learn the skill in a different form.
 - Person Responsible: Developmental Disabilities Administrator with oversight by the Program Area Director
 - Completion Date: December 10, 2019
9. All Habilitation Plan Administrators will be in-serviced on analyzing data and monitoring of programs to ensure that programs are modified to provide the most appropriate training opportunities. This in-service will include modifying programs when there is a lack of progress an ways to make adjustments to see if the Clients can learn the skill in a different form.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: December 10, 2019
10. All Attendant Counselor Managers will be in-serviced on how to complete and implement the weekly data gap monitoring tool.
 - Person Responsible: Program Area Director

Signature / Title

Date

- Completion Date: December 10, 2019

Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing program reviews, they will ensure the Active Treatment Schedules reflect the current programs, supervision, and communication strategies.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. When the Developmental Disabilities Administrators are completing the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
3. The Developmental Disabilities Administrators will complete one observation a month to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
4. The Quality Assurance Department will complete data gap checks once a month then send the results to the Interdisciplinary Teams.
 - Person Responsible: Quality Assurance Department
5. The Quality Assurance Department will include monitoring of data in the Qualified Intellectual Disabilities Professional Reviews when completing chart reviews. The results will be reported out to the Habilitation Plan Administrator, the Developmental Disabilities Administrators, and the Program Area Director.
 - Person Responsible: Quality Assurance Department
6. The Quality Assurance Department will complete one program implementation observation per week with the results of the observations reported to the Developmental Disabilities Administrator and Program Area Director.
 - Person Responsible: Quality Assurance Department

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Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W159 QIDP-Client #5

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure their Qualified Intellectual Disability Professional (QIDP) oversaw every part of three of eight Sample Clients' (Clients #1, #2, and #5) active treatment training plans. The QIDP did not update Client #1's bathing program to reflect her current training plans. The QIDP did not ensure Client #2's teaching plans provided clear instructions for staff to implement; his active treatment schedule did not reflect his most current individual Habilitation plan (IHP); Direct Care Staff (DCS) did not implement teaching plans as written, did not record data as required for analysis; and the Client's programs were not updated when objectives were achieved. The QIDP did not change Client #2's programs where refusals occurred or when no progression occurred for several months of teaching the same objective. The QIDP did not train Client #5's DCS when a program's time was changed from AM to PM, his teaching plans had conflicting prompts for DCS, DCS did not provide data to analyze programs, his training instructions were not changed when his work schedule changed, and his rights were restricted with the authorization from the Human Rights Committee (HRC). The lack of oversight by the QIDPs perpetuated the dysfunction within the facility's Active Treatment loop.

Facility Analysis of the Processes that led to the Deficiency:

- When Client #5 resumed the community employment position, Client #5's daily schedule changed but the programming for Client #5 was not effectively changed to accommodate the change in schedule. This resulted in several programs either not getting run or not having data because the Direct Care Staff were confused by changes. It is stated that an in-service regarding the changes occurred; however, the in-service could not be produced therefore it appears the staff were not in-serviced on the changes. When Client #5's adaptive equipment consent went through Human Rights Committee on August 8, 2019 it was not approved due to the rationale not appearing to support the restriction. There was a discussion with the Habilitation Plan Administrator who was present at the meeting regarding the disapproval. The discussion concluded with the Habilitation Plan Administrator stating they would go back to the Interdisciplinary Team to discuss whether the restriction needed to be put into place. It is unclear whether the discussion occurred or not. The adaptive equipment was not discontinued or removed from Client #5's program and a consent was never revised to send back through Human Rights Committee for approval. This resulted in a restriction being in place without due process.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is November 1, 2019

Immediate Actions:

- Client #5's programming will be updated to reflect the most current changes in Client #5's schedule.

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- Client #5's Learning to Rinse in the Shower program has been updated to ensure that all prompt levels match to ensure consistency.
- A new consent for the adaptive dining equipment was obtained which will go through Human Rights Committee in November 2019. Until due process is obtained, the adaptive dining equipment is encouraged but not required. The team continues to assess to determine if the adaptive equipment is truly needed.

STEPS FOR POC:

1. Client #5's lunch training program was updated to reflect the current shift and days to accommodate Client #5's return to community employment. The Direct Care Staff were in-serviced on the new changes in the program.
 - Person Responsible: Habilitation Plan Administrator
 - Completion Date: November 1, 2019
2. The Habilitation Plan Administrator responsible for Client #5's programs will be in-serviced to maintain record of all in-services that are completed.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: November 15, 2019
3. A new adaptive dining equipment consent was obtained by the Habilitation Plan Administrator that will go through the Human Rights Committee for review in November 2019. If the consent is approved by the Human Rights Committee this time, the adaptive dining equipment will be implemented.
 - Person Responsible: Habilitation Plan Administration
 - Completion Date: November 26, 2019
4. Client #5's training program for Learning to Rinse in the Shower was updated to have clear and consistent prompts. The Direct Care Staff were in-serviced on the updated program so staff know which prompt to be using.
 - Person Responsible: Habilitation Plan Administrator
 - Completion Date: November 1, 2019
5. All Clients will have the instructions reviewed to ensure that the prompt levels are consistent. If they are not, the Habilitation Plan Administrator will update the program and in-service the Direct Care Staff.
 - Person Responsible: Habilitation Plan Administrator
 - Completion Date: December 10, 2019
6. Client #5's Copying Trip Slips and Packing a Lunch for Work programs were updated to reflect the modification in Client #5's schedule.
 - Person Responsible: Habilitation Plan Administrator
 - Completion Date: November 1, 2019

Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Signature / Title

Date

2. The Quality Assurance Department will complete a chart review for consents that were disapproved by the Human Rights Committee to ensure the correct follow up was completed such as, but not limited to, the restriction being removed from the program.
- Person Responsible: Quality Assurance Department

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Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W195 Active Treatment Services

- This condition is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure they had a system to provide four of eight Sample Clients (Clients #1, #4, #6, and #7) with active treatment. Client #1 did not have training throughout the day. Client #4 refused most training activities and there was no plan to address this which resulted in a lack of training through his day. Client #6 was in constant motion through most of the day and there was no plan to address this which resulted in a lack of training throughout her day. Client #7 often refused to do things when staff approached him and there was no plan to address this which resulted in a lack of training throughout his day. Lack of a system to provide prevented them from learning the skills they need to increase their independence and move out of the facility.

Facility Analysis of the Processes that led to the Deficiency:

- The facility failed to adequately assess the needs of Client #1, #4, #6, and #7 and to implement training programs based upon those needs. The facility also failed to address how to manage Client #4 and #7's refusals to participate and/or engage in training. The Direct Care Staff failed to implement training opportunities and to implement plans as directed. The Interdisciplinary Team identified the potential barriers to training and/or working with Client #6, however, the assessments did not provide any methods and/or approaches needed to work with Client #6 to overcome these barriers, particularly their inability to be still and focus. This prevented the implementation of consistent, aggressive active treatment.
- Upon returning from the hospital, the facility failed to implement an Individual Habilitation Plan Revision to address Client #1's change in condition, including what level of active treatment and general activities they were capable of participating in safely, within identified facility timelines. Direct Care Staff failed to provide consistent training due to a lack of understanding of Client #1's current capabilities. As a result, they maintained engagement, but did not push the client to participate in training for any identified skills.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 24, 2019.

Immediate Actions:

- Client #1 was transitioned to a nursing facility.
- The Program Area Team Director and Developmental Disabilities Administrators began conducting observations, working with staff, and assessing needs to best support the clients. The mini-teams for Client #4, #6, and #7 met to discuss how best to address their needs in terms of active treatment and plan implementation.

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- The Administrative Team met to discuss staffing and identified options needed and how best to provide greater consistency for the clients and staff.

STEPS FOR POC:

1. All assessments and training programs for Client #4, #6, and #7 will be reviewed by the Interdisciplinary Team to determine what changes should be made to better meet their assessed needs and active treatment goals.
 - Person Responsible: Habilitation Plan Administrator with oversight by Program Area Team Director.
 - Completion Date: December 1, 2019
2. All Habilitation Plan Administrators will review and update the Active Treatment Schedules and training plans to ensure that they reflect the assessed needs of the client, including how to address identified barriers to client participation in training.
 - Person Responsible: Habilitation Plan Administrator with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019
3. Program Authors will observe the implementation of the programs for Client #4, #6, and #7 to ensure that they are meeting the assessed needs of the clients and that they are being implemented correctly.
 - Person Responsible: Program Area Team Director.
 - Completion Date: December 31, 2019
4. All Direct Care Staff will be in-serviced on the use of the Active Treatment Schedule as a tool to identify learning opportunities and ongoing training for the clients.
 - Person Responsible: Habilitation Plan Administrator with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019
5. All Direct Care staff will be in-serviced on the updated training programs and Active Treatment Schedule changes identified for Client #4, #6, and #7, as well as other individuals that have been identified as needing updates to their programs and active treatment schedule.
 - Person Responsible: Habilitation Plan Administrator with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019
6. Management staff will implement a unit involvement plan which will include observations, working directly with staff, assessing clients, and meetings with mini-teams to write and implement appropriate plans to ensure continuous active treatment. The Management staff will attend mini-team meetings to assist with facilitation and ensure that the meeting includes discussion about client training programs and progress.
 - Person Responsible: Program Area Team Director
 - Completion Date: December 31, 2019

Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing the reviews of the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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2. The Habilitation Plan Administrator will complete one observation a week to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Developmental Disabilities Administrators
3. The Developmental Disabilities Administrators will complete one observation a month to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W196 Active Treatment-Client #1

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to provide aggressive active treatment for four of eight Sample Clients (Clients #1, #4, #6, and #7). Client #1 had a lack of training programs that would occupy most of her day. She spent long periods of the day sitting around, without training. Client #4 and #6 experienced numerous missed opportunities for training. There was no assessment of, or plan to, address client #4's refusals to participate in training. There was no plan to address Client #6's constant movement that interfered with training. Client #7 had a training program repeatedly implemented incorrectly, or not implemented at all, and lack of training programs that would occupy most of his day. This failure resulted in Clients' primary opportunity to learn being missed because of the facility's dysfunction without the active Treatment loop.

Facility Analysis of the Processes that led to the Deficiency:

- Upon returning from the hospital, the facility failed to implement an Individual Habilitation Plan Revision to address Client #1's change in condition, including what level of active treatment and general activities she was capable of participating in safely, within identified facility timelines. Direct Care Staff failed to provide consistent training due to a lack of understanding of her current capabilities. As a result, they maintained engagement, but did not push her to participate in training for any identified skills.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 24, 2019.

Immediate Actions:

- Client #1 transitioned to a nursing facility.
- The Program Area Team Director and Developmental Disabilities Administrators began conducting observations, working with staff, and assessing needs to best support the clients. The mini-team for Client #1 met to discuss how best to address the needs of Client #1 in terms of active treatment and plan implementation.

STEPS FOR POC:

- All Habilitation Plan Administrators will review and update the Active Treatment Schedules and training plans to ensure that they reflect the assessed needs of the client, including needs surrounding challenges in engagement and focus.
 - Person Responsible: Habilitation Plan Administrator with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019

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2. All Direct Care Staff will be in-serviced on the use of the Active Treatment Schedule as a tool to identify learning opportunities and ongoing training for the clients.
 - Person Responsible: Habilitation Plan Administrator with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019
3. The Occupational Therapists will in-service all Direct Care Staff and Adult Training Specialist staff on appropriate methods of reinforcing and/or training fine and gross motor skills so that they are better able to correct and train to the client's needs.
 - Person Responsible: Occupational Therapist with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019
4. All Adult Training Specialists will be in-serviced regarding the expectation that they will implement all training programs and follow the active treatment schedule to ensure that clients receive consistent training in all identified areas of need.
 - Person Responsible: Adult Program Supervisor with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019
5. All Direct Care Staff will be in-serviced regarding the expectation that they will implement all training programs and follow the active treatment schedule to ensure that clients receive consistent training in all identified areas of need.
 - Person Responsible: Habilitation Plan Administrator with oversight by Program Area Team Director.
 - Completion Date: December 31, 2019

Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. The Habilitation Plan Administrator will complete one observation a week to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Developmental Disabilities Administrators
3. The Developmental Disabilities Administrators will complete one observation a month to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Signature / Title

Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W196 Active Treatment-Client #4

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to provide aggressive active treatment for four of eight Sample Clients (Clients #1, #4, #6, and #7). Client #1 had a lack of training programs that would occupy most of her day. She spent long periods of the day sitting around, without training. Client #4 and #6 experienced numerous missed opportunities for training. There was no assessment of, or plan to, address client #4's refusals to participate in training. There was no plan to address Client #6's constant movement that interfered with training. Client #7 had a training program repeatedly implemented incorrectly, or not implemented at all, and lack of training programs that would occupy most of his day. This failure resulted in Clients' primary opportunity to learn being missed because of the facility's dysfunction without the active Treatment loop.

Facility Analysis of the Processes that led to the Deficiency:

- The facility failed to adequately assess the needs of Client #4 and implement training programs based upon those needs. The facility also failed to address how to manage Client #4's refusals to participate and/or engage in training. The Direct Care Staff failed to implement training opportunities.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 24, 2019.

Immediate Actions:

- The Program Area Team Director and Developmental Disabilities Administrators began conducting observations, working with staff, and assessing needs to best support the clients. Client #4 met to discuss how best to address the needs of Client #4 in terms of active treatment and plan implementation.

STEPS FOR POC:

- Assessments and observations will be completed for Client #4 and the Habilitation Plan Administrator for Client #4 will update all training programs and active treatment schedule to address all identified needs and the refusal to participate in active treatment.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Program Area Team Director
 - Completion Date: December 6, 2019
- The Habilitation Plan Administrator will in-service Direct Care Staff that work with Client #4 on the updated training programs and active treatment schedule.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Program Area Team Director
 - Completion Date: December 6, 2019

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Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. The Habilitation Plan Administrator will complete one observation a week to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Developmental Disabilities Administrators
3. The Developmental Disabilities Administrators will complete one observation a month to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Date

Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W196 Active Treatment-Client #6

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to provide aggressive active treatment for four of eight Sample Clients (Clients #1, #4, #6, and #7). Client #1 had a lack of training programs that would occupy most of her day. She spent long periods of the day sitting around, without training. Client #4 and #6 experienced numerous missed opportunities for training. There was no assessment of, or plan to, address client #4's refusals to participate in training. There was no plan to address Client #6's constant movement that interfered with training. Client #7 had a training program repeatedly implemented incorrectly, or not implemented at all, and lack of training programs that would occupy most of his day. This failure resulted in Clients' primary opportunity to learn being missed because of the facility's dysfunction without the active Treatment loop.

Facility Analysis of the Processes that led to the Deficiency:

- The Interdisciplinary Team identified the potential barriers to training and/or working with Client #6, however, the assessments did not provide any methods and/or approaches needed to work with Client #6 to overcome these barriers, particularly their inability to be still and focus. This prevented the implementation of consistent, aggressive active treatment.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 24, 2019.

Immediate Actions:

- The Program Area Team Director and Developmental Disabilities Administrators began conducting observations, working with staff, and assessing needs to best support the clients. The mini-team for Client #6 met to discuss how best to address the needs of Client #6 in terms of active treatment and plan implementation.

STEPS FOR POC:

- Based upon the updated assessments and observations, the Habilitation Plan Administrator for Client #6 will complete an Individual Habilitation Plan Revision, and update all training programs and the active treatment schedule to address all identified needs, including the need for constant motion and the inability to focus on tasks.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Program Area Team Director
 - Completion Date: December 6, 2019
- The Psychologist will review Client #6's Functional Replacement Behavior Plan and Positive Behavior Support Plan Staff Instructions and update to address how to work with Client #6's need for constant motion and the inability to focus on tasks in order to provide more guidance to Direct Care Staff when

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working with Client #6. The frequency of the plan's use will also be reviewed to identify what is more appropriate to Client #6's behavioral and training needs.

- Person Responsible: Psychologist with oversight by the Chief Psychologist
 - Completion Date: December 6, 2019
3. The Psychologist will in-service Direct Care Staff that work with Client #6 on the updated Functional Replacement Behavior Plan and Positive Behavior Support Plan Staff Instructions regarding how to work with Client #6's need for constant motion and the inability to focus on tasks.
 - Person Responsible: Psychologist with oversight by the Chief Psychologist
 - Completion Date: December 6, 2019
 4. The Habilitation Plan Administrator will in-service Direct Care Staff that work with Client #6 on the Individual Habilitation Plan Revision, the updated training programs, and active treatment schedule.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Program Area Team Director
 - Completion Date: December 6, 2019
 5. The Habilitation Plan Administrators will review and analyze the previous month's program data to identify Clients on their caseloads that engage in behaviors that interfere with skill acquisition. The Habilitation Plan Administrators will turn this information into the Developmental Disabilities Administrators for review.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: November 15, 2019
 6. Clients identified that are engaging in behaviors that interfere with skill acquisition will have their Interdisciplinary Teams meet to discuss their plans and necessary changes. Once the changes are made revisions to the identified Clients' program will be done and staff will be in-serviced.
 - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: December 13, 2019

Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. The Habilitation Plan Administrator will complete one observation a week to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Developmental Disabilities Administrators
3. The Developmental Disabilities Administrators will complete one observation a month to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.

- Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Plan of Correction

DATE OF SOD

10/11/2019

DATE OF POC

10/28/2019

CITATION

Citation: W196 Active Treatment-Client #7

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to provide aggressive active treatment for four of eight Sample Clients (Clients #1, #4, #6, and #7). Client #1 had a lack of training programs that would occupy most of her day. She spent long periods of the day sitting around, without training. Client #4 and #6 experienced numerous missed opportunities for training. There was no assessment of, or plan to, address client #4's refusals to participate in training. There was no plan to address Client #6's constant movement that interfered with training. Client #7 had a training program repeatedly implemented incorrectly, or not implemented at all, and lack of training programs that would occupy most of his day. This failure resulted in Clients' primary opportunity to learn being missed because of the facility's dysfunction without the active Treatment loop.

Facility Analysis of the Processes that led to the Deficiency:

- The facility failed to adequately assess the needs of Client #7 and implement training programs based upon those needs. The facility also failed to address how to manage Client #7's refusals to participate and/or engage in training. The Direct Care Staff failed to implement training opportunities and to implement plans as directed.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is October 24, 2019.

Immediate Actions:

- The Program Area Team Director and Developmental Disabilities Administrators began conducting observations, working with staff, and assessing needs to best support the clients. The mini-team for Client #7 met to discuss how best to address the needs of Client #4 in terms of active treatment and plan implementation.

STEPS FOR POC:

- Based upon the updated assessments and observations, the Habilitation Plan Administrator for Client #7 will update all training programs and active treatment schedule to address all identified needs and the refusal to participate in active treatment.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Program Area Team Director
 - Completion Date: December 6, 2019
- The Psychologist will review Client #7's Functional Replacement Behavior Plan and Positive Behavior Support Plan Staff Instructions and update to address how to implement training plans and work with Client #7 when engaging in maladaptive behaviors and refusals to engage in training. The frequency of

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the plan's use will also be reviewed to identify what is more appropriate to Client #7's behavioral and training needs.

- Person Responsible: Psychologist with oversight by the Chief Psychologist
 - Completion Date: December 6, 2019
3. The Psychologist will in-service Direct Care Staff that work with Client #7 on the updated Functional Replacement Behavior Plan and Positive Behavior Support Plan Staff Instructions regarding how to implement training plans and work with Client #7 when engaging in maladaptive behaviors and refusals to engage in training.
- Person Responsible: Psychologist with oversight by the Chief Psychologist
 - Completion Date: December 6, 2019
4. The Habilitation Plan Administrator will in-service Direct Care Staff that work with Client #7 on the updated training programs and active treatment schedule.
- Person Responsible: Habilitation Plan Administrator with oversight by the Program Area Team Director
 - Completion Date: December 6, 2019

Monitoring Procedure for Implementing the POC:

1. When the Developmental Disabilities Administrators are completing the monthly Qualified Intellectual Disabilities Professional Reviews, they will ensure program modifications have been implemented by reviewing the teaching programs as well.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. The Habilitation Plan Administrator will complete one observation a week to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Habilitation Plan Administrator with oversight by the Developmental Disabilities Administrators
3. The Developmental Disabilities Administrators will complete one observation a month to ensure that training programs are being implemented as written. The information gained from the observations will be reported to the Program Area Director.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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